CMS NET ENHANCEMENT 47 PROJECT

SERVICE AUTHORIZATION REQUESTS

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1 INTRODUCTION

1.1 PURPOSE OF DOCUMENT

This document presents a functional overview of the screens, screen flows, and high level requirements pertaining to service authorization requests (SAR's). The document presents a brief description of how SAR's will be authorized under E47, along with screen flows, sample screens, data dictionaries for each screen, and business rules for each screen.

1.2 LIST OF ACROYMS

Several acronyms may be used throughout this document. The following presents a list of acronyms and their definition.

Table 1.1, List of Acronyms

Term	Definition
CATS	Common Application Transaction System
CA-MMIS	MediCaid Management Information System (The EDS System)
CCS	California Children's Services
CHDP	Child Health and Disability Prevention Program
CIN	Client Index Number
CMS	Children's Medical Services
DHS	Department of Health Services
DSB	Data Systems Branch
E47	Enhancement 47
EDS	Electronic Data Systems
GHPP	Genetically Handicapped Persons Program
HAP	Health Access Programs
HF	Healthy Families
HIS	Health Insurance System
ITSD	Information Technology Services Division
MTU	Medical Therapy Unit
PMF	Provider Master File
SAF	Service Authorization File
SAR	Service Authorization Request
SCI	Statewide Client Index
SFD	System Functional Design
TPL	Third Party Liability
TPLB	Third Party Liability Branch
VIP	Visionary Integration Professionals

1.3 ASSUMPTIONS AND CONSTRAINTS

The following assumptions and / or constraints apply to this document:

- The material contained in this package was in development stages at the time the RFP is released. Some additional specifications and requirements may need to be defined in order to complete the service authorization component. A list of items which should be included in the final system delivered to CCS but which are not addressed in detail in this document is presented in Section 6 of this document.
- The material contained in this package has been reviewed by users of the CMS Net system. However, a final validation of these specifications must be conducted prior to the commencement of development.
- This document does not address user security levels and the functions associated with each security level. Access to specific functions based on an individual's security level must be defined, incorporated in the SAR functional specifications, and implemented as a part of E47.
- The screens presented in this document are text based and are included to illustrate the functions of, and data elements on, each screen. The actual screens which are implemented should conform to the agreed upon project standards for user presentation. It is anticipated that this standard will be a form of a graphical user or browser based interface. The interface will include drop down menus, list boxes (which provide values to select for some fields), help text, pop-up help messages, and narrative values on screens instead of codes. The utilization of narrative values instead of codes may require the development of tables that translate codes in the database to the narrative values.
- Reports will be generated from the CMS Net database as well as from the fiscal intermediary systems. The fiscal intermediaries will be responsible for reports based on data in the SAF and from other fiscal intermediary systems. Reports from CCS data will be derived from CMS Net. CMS Net reporting requirements are not addressed in this document. Reporting from CMS Net will be addressed a separate document which comprehensively states the CMS reporting requirements on data that resides in CMS Net.
- Requests Entered, Authorized, Denied, Cancelled, or Modified prior to implementation of E47 will not be converted but will be accessed through the Display Events function of the CMS Net legacy system. The authorizations in the legacy system will be display only. If modifications to an authorization in the legacy system are required, a new SAR must be created through the enhanced CMS Net system.
- The SAR screens and its associated processes shall behave similarly when accessed from different screens. Screens will also have a common look, menus, and interface.
- This document does not address requirements or changes to CMS Net due to HIPAA. Changes to CMS Net, however, are anticipated as a result of HIPAA requirements. A separate effort will be undertaken to assess and identify HIPAA

related changes to CMS Net. A strategy for implementing HIPAA related changes to CMS Net will be developed upon completion of this assessment. These changes may require modifications to the specifications, functional requirements, or other information contained in this document.

1.4 CURRENT AND FUTURE SAR PROCESSING

This section provides an overview of SAR processing. It includes an overview of the current process, a description of the problems and opportunities inherent in the current process, key objectives of E47, and a description of the SAR process which is envisioned after E47 is implemented.

1.4.1 Current SAR Process

All services provided to CCS clients under the CCS program must be authorized in advance by CMS staff (under certain conditions, such as emergencies, prior authorization is not necessary). The SAR is used to request approval for CCS services. SAR's are typically initiated by a provider or CCS client, who submits the request via telephone, fax, or mail. SAR's are submitted to a CCS regional office or independent county. Once the SAR is received, CCS case workers enter the request information into CMS Net. The workers conduct a manual review of the SAR to determine the client's eligibility to receive CCS services. The requested services are also reviewed by CCS medical staff. If the client is eligible and the services are deemed medically appropriate, the services are approved. The entire SAR or specific services could also be denied if the patient is not eligible, or if the requested services are not deemed appropriate. Moreover, consistent with its case management activities, CMS staff can approve different or additional services than those requested.

After the services are approved, CMS staff then selects an enrolled CCS provider to provide the services. Manual provider files and other documentation which currently exist outside of CMS Net are used for this purpose. The selected provider could be the provider who submitted the request, or another provider selected by CMS staff.

Once the services are approved and a provider has been selected, CMS Net generates a written authorization letter which documents the approved services. The letter is sent to the selected providers and the client. The authorization data is stored in CMS Net, but is not currently transmitted to the fiscal intermediaries for claims processing.

After receiving authorization, the services are rendered by the provider. In order to be paid for the services rendered, providers must submit a claim to the CCS regional office or independent county that originally approved the authorization. When a claim is received, it is logged and manually reviewed by CMS staff to ensure that patient is eligible for the program and that the provider is billing for authorized services. Other program and policy rules are applied to ensure that the claim is valid. Denied claims are returned to the provider with a notice indicating the reason for the denial. Approved claims are date stamped by CCS staff and forwarded to EDS for payment.

Some providers submit claims electronically. Hardcopies of electronic claims are still sent to the CCS regional office or independent county for review and approval.

However, rather than forwarding the claims to the fiscal intermediary after they are approved, CCS staff returns the claims to the provider. The provider then submits the claim electronically to EDS for adjudication.

EDS currently adjudicates almost all CCS claims, including dental claims. EDS processes claims on a nightly basis. After the claim is processed, EDS generates a remittance advice which is sent to the State Controllers Office. The State Controller's office uses the remittance advice to generate a check for the provider.

1.4.2 Current Process Issues and Opportunities

The process described above provides many opportunities to streamline and strengthen the service authorization and claims payment processes. Issues with the current process which can be addressed by enhancements to CMS Net and their associated business processes include:

1. Treatment / diagnostic authorization forms from non-CMS counties are not standardized. Many providers serve multiple counties and must be knowledgeable of different procedures and forms depending upon which county issues the authorization.
2. Authorizations currently do not use standard procedure codes or categories of service. Treatment plans are written in narrative format, requiring manual review of the service request and claim to ensure that only those procedures authorized are paid. Automated edits would enhance the claims adjudication process.
3. Claims processing contains many manual steps and is labor intensive for CCS. Manual processes increase the likelihood that claims will be paid from the wrong funding source, with an estimated cost of $500,000 annually to the CCS program.
4. Multiple provider files exist, none of which contain all of the necessary data for provider enrollment, case management, issuing service authorizations, or adjudicating claims.
5. A single, statewide CCS patient file does not exist. Consequently, some of the information required for verify patient eligiblity, or to make key program management and program design decisions does not exist, or is not readily available. The absence of this information also creates labor intensive work for management reporting, administrative decisions, and managing the transfer of cases from county to county.
6. All CCS counties have been required to process claims via the State's fiscal intermediaries since January 1, 1999. This presents opportunities to enhance the service authorization and validation process. Delta Dental and Electronic Data Systems (EDS) have been selected as the dental and medical fiscal intermediaries. EDS currently processes most CCS dental claims. This process can be cumbersome, however, because the current EDS system and associated business processes are geared towards processing medical claims, rather than dental claims.
7. The requirement to submit all claims to the medical and dental fiscal intermediaries will enable providers to send claims directly to the fiscal intermediaries, rather than to the county or regional CCS offices for verification prior to forwarding them to the

fiscal intermediary. Removing the counties and regional offices streamlines this process, but requires the implementation of new service authorization procedures and the transmittal of authorization data to the Delta Dental and EDS,

8. Current CMS Net authorization screens use “roll and scroll” as the method for entering data, rather than a more conventional interface.

1.4.3 E47 Service Authorization Objectives

Given the above, the key objectives of the service authorization component of the E47 project are to:

1. Define and standardize the service authorization process so that a single process is used for all CCS counties and regional offices.
2. Automate authorization and processing of claims so that all claims are submitted by providers directly to EDS and Delta Dental for payment, and automated edits are used to replace the manual review of claims and authorizations.
3. Issue authorizations on-line that utilize quantifiable, time-limited, and service-specific codes.
4. Enhance CMS Net so that the system provides enhanced data entry capability, including full screens and a graphical user or “browser based” interface.
5. Create a statewide Service Authorization File (SAF) database that can be used for automated edits of claims, on-line queries, and reporting. Transmit data to the SAF electronically. The authorization file should be accessible to CMS, EDS, and Delta Dental for SAR and claims processing.
6. Remove barriers such as manual review processes, stamps, and handwriting so that more providers might elect so submit claims electronically.

1.4.4 Future Functional Description

Based on the above objectives of E47, several changes will be made to CMS Net service authorization functionality.

E47 requires new or enhanced automated processes to support the processing of SAR’s and the adjudication of claims. Under E47, CMS staff will have the ability to generate authorizations using procedure, category of service, or other specific codes which will specifically delineate the services to be performed. These services, as indicated by the specific codes, will have a specific quantity and will be service specific, time limited. Under E47, CMS Net will provide enhanced screens for entering, authorizing, denying, modifying, canceling, or extending a SAR.

When a SAR is initially approved by a CCS caseworker, CMS Net will send an electronic transaction to either the medical (EDS) or dental (Delta Dental) fiscal intermediary. The transaction will include information on the approved authorization, such as the authorization number, patient name, provider name, and the number and type of authorized services. CMS Net will utilize standard codes for authorizations and procedures, and all authorizations will have a unique authorization number. This

information will be stored in one of two Service Authorization Files that will exist at the medical (EDS) and dental (Delta Dental) fiscal intermediaries.

Transactions between CMS Net and the SAF will be “one way”, e.g. CMS Net will send transactions to each SAF but will not receive any data from the fiscal intermediaries in return. The fiscal intermediaries will be responsible for developing and maintaining the SAF. CMS Net will transmit data to the SAF by sending transactions for authorized, modified, canceled, or extended authorizations. The data will be sent to the SAF on a real time basis.

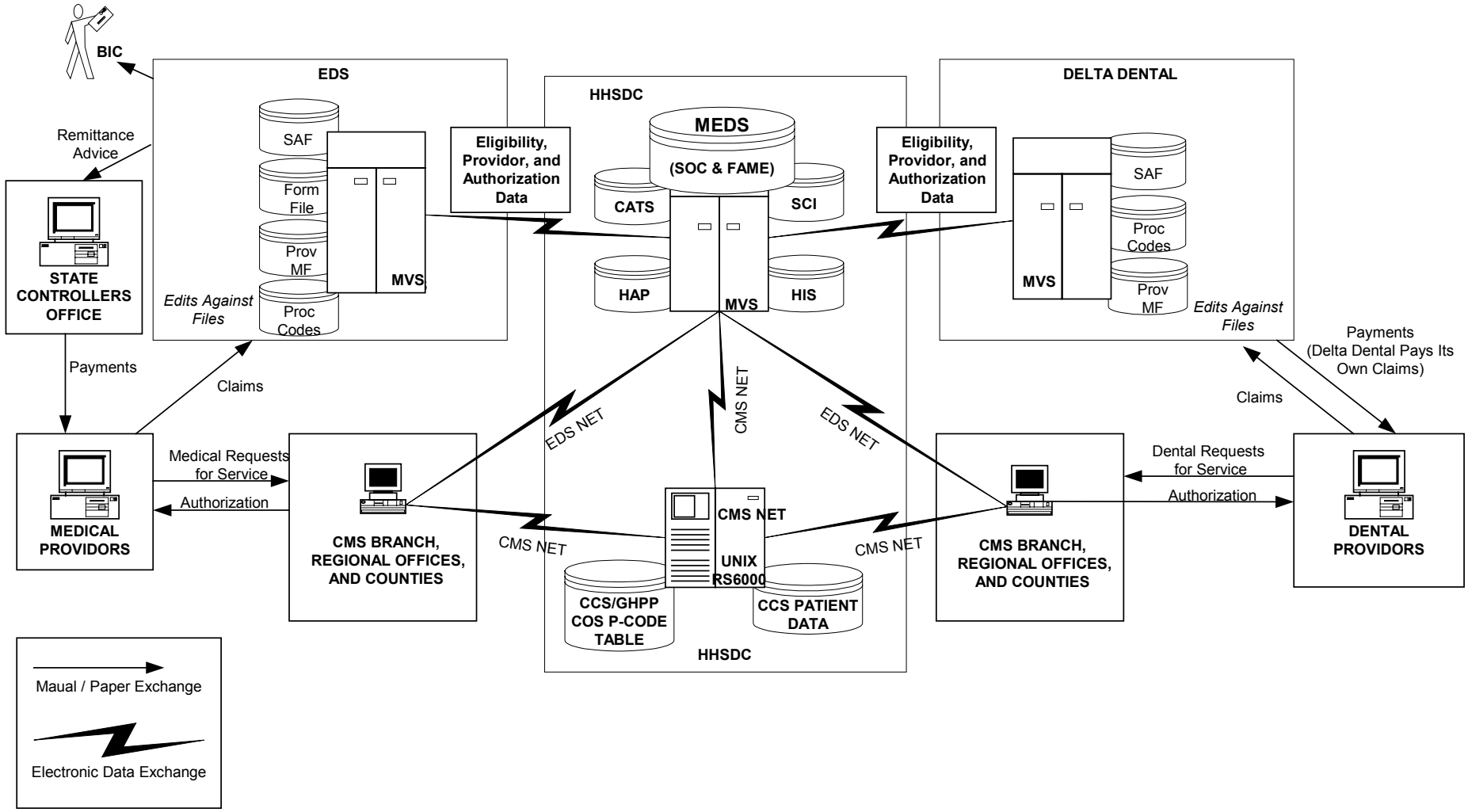
After providing the services authorized by the SAR, providers will be required to submit claims directly to the fiscal intermediaries for adjudication (this process streamlines the claims adjudication process by eliminating the step where claims are sent to a regional or county CMS office for a manual review and approval, and then forwarded to the fiscal intermediary for payment). Using the information in the SAF and other files, the fiscal intermediary will apply automated edits to the claim and adjudicate it.

The functional specifications in this document identify the changes required for the service authorization component of CMS Net, consistent with the changes described above. Related changes to the systems and business processes for claims adjudication will be made by EDS and Delta Dental.

1.5 FUTURE TECHNICAL ARCHITECTURE

The future technical architecture is presented below. It includes the addition of Delta Dental as the dental fiscal intermediary; access to other State systems for increased information on CCS patients, and the implementation of or connectivity to several files (such as the provider master file, service authorization file, and procedure code files) for claims adjudication.

Figure 1-2
Future Systems Architecture


BIC
EDS
HHSDC
DELTA DENTAL
Remittance Advice
SAF
Form File
Prov MF
Proc Codes
MVS
Edits Against Files
Eligibility, Providor, and Authorization Data
MEDS
(SOC & FAME)
CATS
SCI
HAP
HIS
MVS
Eligibility, Providor, and Authorization Data
SAF
Proc Codes
Prov MF
MVS
Edits Against Files
STATE CONTROLLERS OFFICE
Payments
Claims
Payments (Delta Dental Pays Its Own Claims)
Claims
EDS NET
CMS NET
EDS NET
Medical Requests for Service
Authorization
MEDICAL PROVIDORS
CMS BRANCH, REGIONAL OFFICES, AND COUNTIES
CMS NET
CMS NET
CMS NET
UNIX RS6000
CCS/GHPP COS P-CODE TABLE
CCS PATIENT DATA
HHSDC
CMS BRANCH, REGIONAL OFFICES, AND COUNTIES
Dental Requests for Service
Authorization
DENTAL PROVIDORS
Maual / Paper Exchange
Electronic Data Exchange

1.6 DOCUMENT OVERVIEW

This presents functional specifications developed to achieve the objectives and design features described in section 1.3 of this document.

This document is divided into four sections. Each section presents the screens, data dictionaries, business rules and other information associated with the SAR business functions. The table below identifies each section of this document and the business or system functions addressed.

Table 1-1, Document Subsections, Business Functions, and Screens

Document Section	Business / System Functions
Section 2: SAR Processing	• Searching for a SAR • Entering a SAR • Authorizing a SAR • Denying a SAR • Modifying a SAR • Extending a SAR • Cancelling a SAR • Correspondence, Narratives, and Ticklers
Section 3: SAR Queries	Medical (EDS) • Procedure Code Inquiry • Provider File Inquiry • Formulary File Inquiry Dental (Delta Dental) • Dental Procedure Code Look-Up • Dental Procedure Code Translation Look-Up Both (Medical and Dental) • SAR Printing
Section 4: SAF Transactions (Data sent to the Fiscal Intermediaries for claims processing)	• SAF Data Elements • Authorize Transaction • Cancel Transaction • Modify Transaction • Extend Transaction

Document Section	Business / System Functions
Section 5: Table and File Maintenance (Required tables / maintenance for SAR processing)	Medical (EDS) • Procedure File • Formulary File • Drugs Requiring Prior Authorization • Category of Service Table (4201- Category of Service to Procedure Code Association) • Provider Type to Category of Service Table (4200) • CCS Category of Service Table (5201) Dental (Delta Dental) • Dental Procedure Code Table • Dental Procedure Code Translation Table

2 SERVICE AUTHORIZATION REQUEST PROCESSING

2.1 INTRODUCTION

SAR's will be entered in CMS Net through a series of screens designed to capture the essential information required to process a SAR. The screens will allow CMS workers to enter information on the patient's diagnosis, select a provider, and enter services. The design features the use of service specific codes which specifically identify the services to be provided.

After information on the diagnosis, provider and services are entered, screens will be provided which enable users to authorize or deny the SAR. Additional screens will be provided which enable users to modify, extend, or cancel an authorized SAR. Some functions, such as the ability to take action on a SAR (authorize, deny, modify, extend, or cancel) or change certain fields on a screen (such as the funding source or client's legal county) require the proper security. The same set of screens will be used to process medical and dental SAR's.

Transactions will be sent to EDS and Delta Dental to add or update records in the Service Authorization Files at each fiscal intermediary. Section 4 of this document provides additional information on SAF transactions.

The table below identifies the screens which require development to support this function. All of these screens *with the exception of the CMSPI-10 Patient Identification Screen* require development. The CMSPI-10 screen has already been developed and is currently in production.

Table 2-1, SAR Processing Screens

Screen	Purpose	Subsection
CMSSMM-10 Medical Service Authorization Request Main Menu	Provides access to all SAR functions.	2.3.1
CMSPI-10 Patient Identification	Used to select a patient during the process of entering a SAR for a patient or for SAR searches.	2.3.2
CMSSAR-10 Medical Service Authorization Request Query	Used to enter the parameters for a SAR query / search.	2.3.3
CMSSAR-20 Medical Service Authorization Request Query Results	Displays the results of a SAR query.	2.3.4
CMSSAR-50 Service Authorization Request Entry	Used to enter patient information and services for a SAR.	2.3.5

Screen	Purpose	Subsection
CMSSAR-60 Authorization of Services	Used to authorize a SAR.	2.3.6
CMSSAR-70 Denial of Services	Used to deny a SAR.	2.3.7
CMSSAR-80 Cancellation of Services	Used to cancel a SAR.	2.3.8
CMSSAR-85 Extension of Services	Used to extend a SAR.	2.3.9
CMSSAR-90 Modification of Services	Used to modify the services on a SAR.	2.3.10
CMSSBM-10 Medical Service Authorization Request Branch Menu	Provides access to SAR functions for selected patient.	2.3.11

2.2 SAR PROCESSING SCREEN FLOW

Users can process SAR's by making an appropriate selection (Enter, Authorize, Deny, Cancel, Extend, Modify) from the CMSSMM-10 Main Menu or the CMSSBM-10 Branch Menu. Screen and process flows for functions originating from Main Menu and Branch Menu are presented below.

2.2.1 Main Menu Processes and Screen Flow

The flow charts on the next two pages illustrate the flow of the SAR processing screens. Figure 2.1 depicts the screens and process for entering, authorizing, or denying a SAR using a single process from the CMSSMM-10 Main Menu.

Figure 2.2 depicts the screens and process for authorizing, denying, canceling, modifying, or extending a SAR from the main menu in a two step process. This process pertains to SAR's which have been entered into CMS Net using the process depicted in figure 2.1, but which were not authorized or denied (e.g., the user chose to "save" the SAR and take action on it later). This two step process allows users to enter some information on a SAR, stop working on it, and return to it later to take action. This process may be used if a CMS staff person needs to conduct additional research to complete the required fields on a SAR. As noted above, Figure 2.2 illustrates the process for authorizing a SAR from the main menu using the CMSMS-60 Authorization of Services screen in the screen flow. CMS Net will allow users to Deny, Modify, Extend, or Cancel a SAR by replacing the CMSMS-60 screen with the CMSMS-70 screen (for denials), or the CMSSAR-80, 85, or 90 screens (for cancellations, extensions, or modifications) respectively, in the same screen flow.

Figure 2.1, SAR Processing Screen Flow

Entering a SAR from the Main Menu

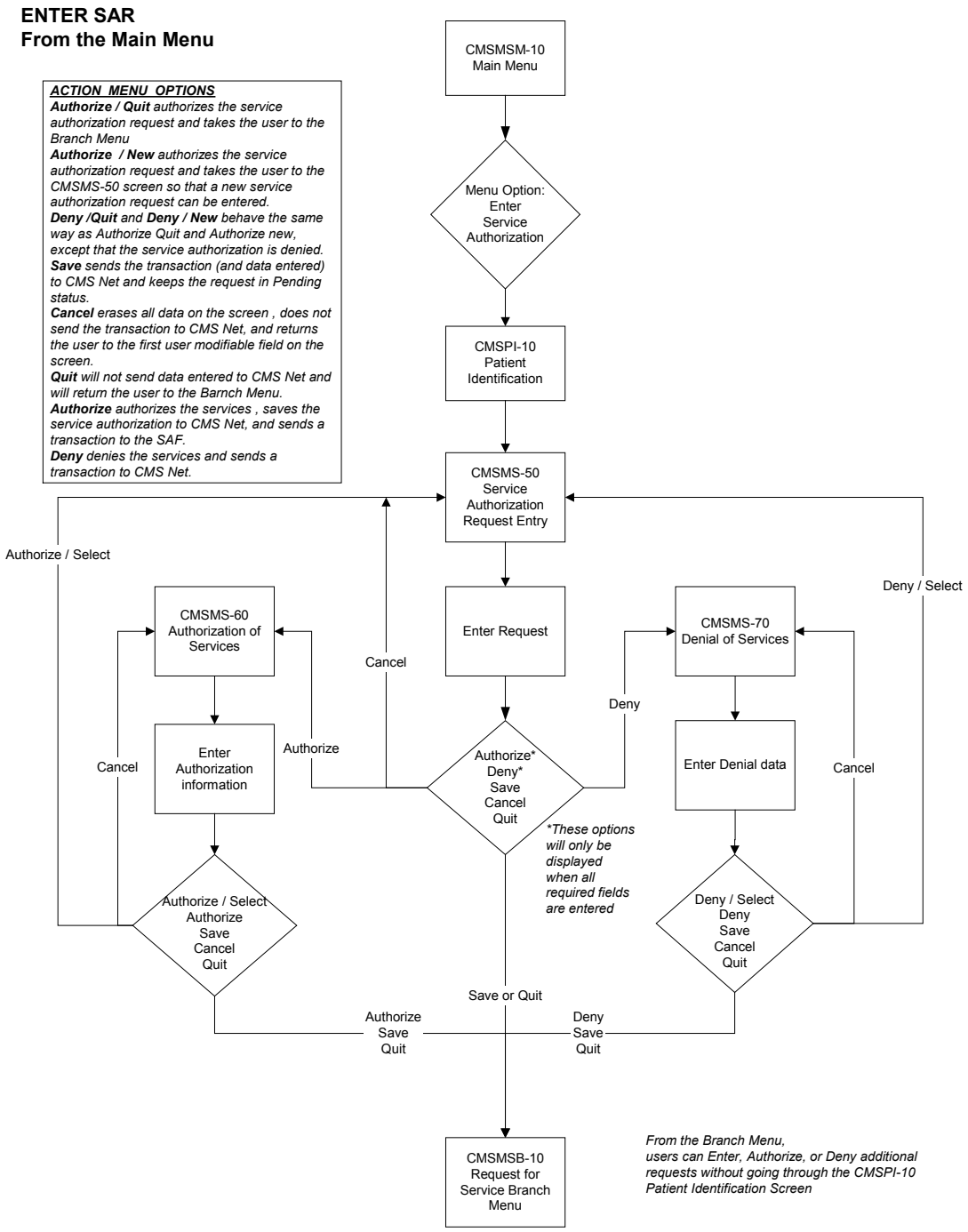
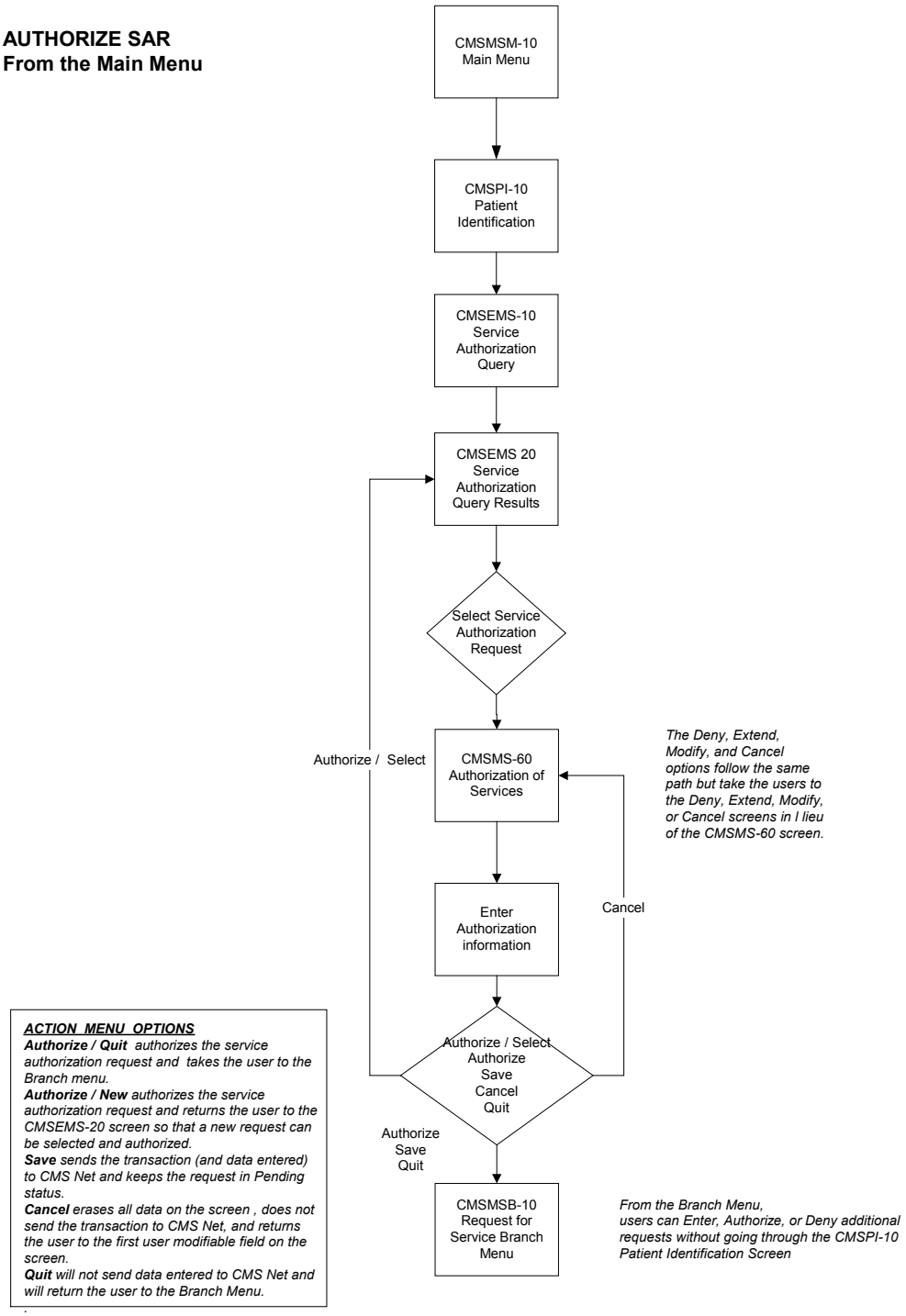


Figure 2.2, SAR Processing Screen Flow

Authorizing a SAR from the Main Menu

AUTHORIZE SAR
From the Main Menu



2.2.2 Branch Menu Processes and Screen Flow

Figures 2.1 and 2.2 on the previous pages depict processes chosen from the CMSSMM-10 Main Menu. Users will also have the option to Enter, Authorize, Modify, Deny, Extend, or Cancel a SAR from the CMSSBM-10 Branch Menu, as illustrated by Figures 2.3 and 2.4 on the next two pages. The primary difference between the flows emanating from Main Menu and Branch Menu is that the CMSPI-10 Patient Identification screen is skipped for all functions emanating from Branch Menu, since a patient is already selected for all Branch Menu functions. If a user is located on the Branch Menu and decides to perform menu functions for a different patient, the user must select the Return to SAR Main Menu function on the Branch Menu and select the appropriate function. The user will then be routed to the CMSPI-10 Patient Identification screen to select a new patient.

As was the case with the main menu functions, CMS Net should allow users to Deny, Modify, Extend, or Cancel a SAR by replacing the CMSMS-60 screen with the CMSMS-70 screen (for denials), or the CMSSAR-80, 85, or 90 screens (for cancellations, extensions, or modifications) respectively, in the same screen flow.

Figure 2.3, SAR Processing Screen Flow

Entering a SAR from the Branch Menu

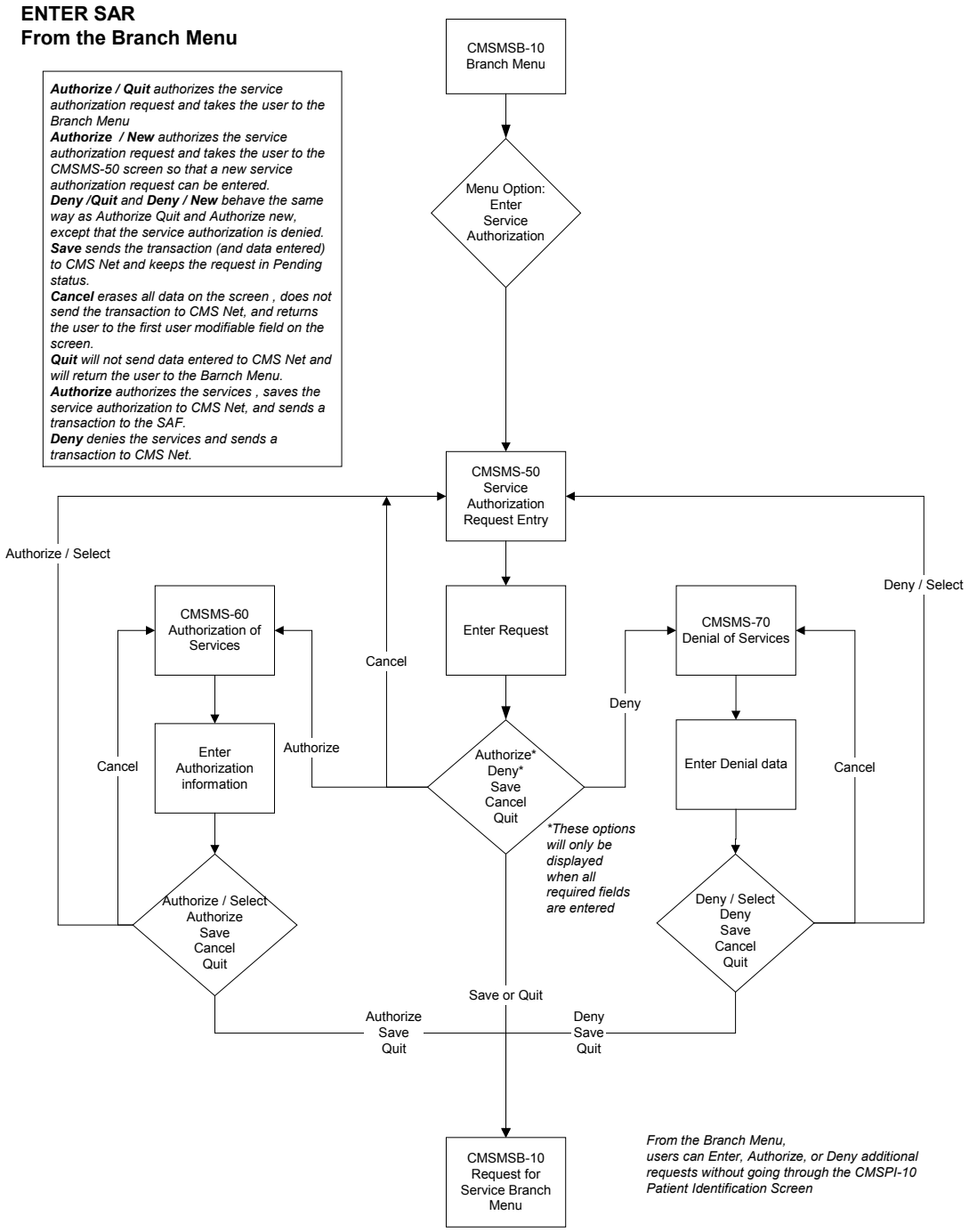
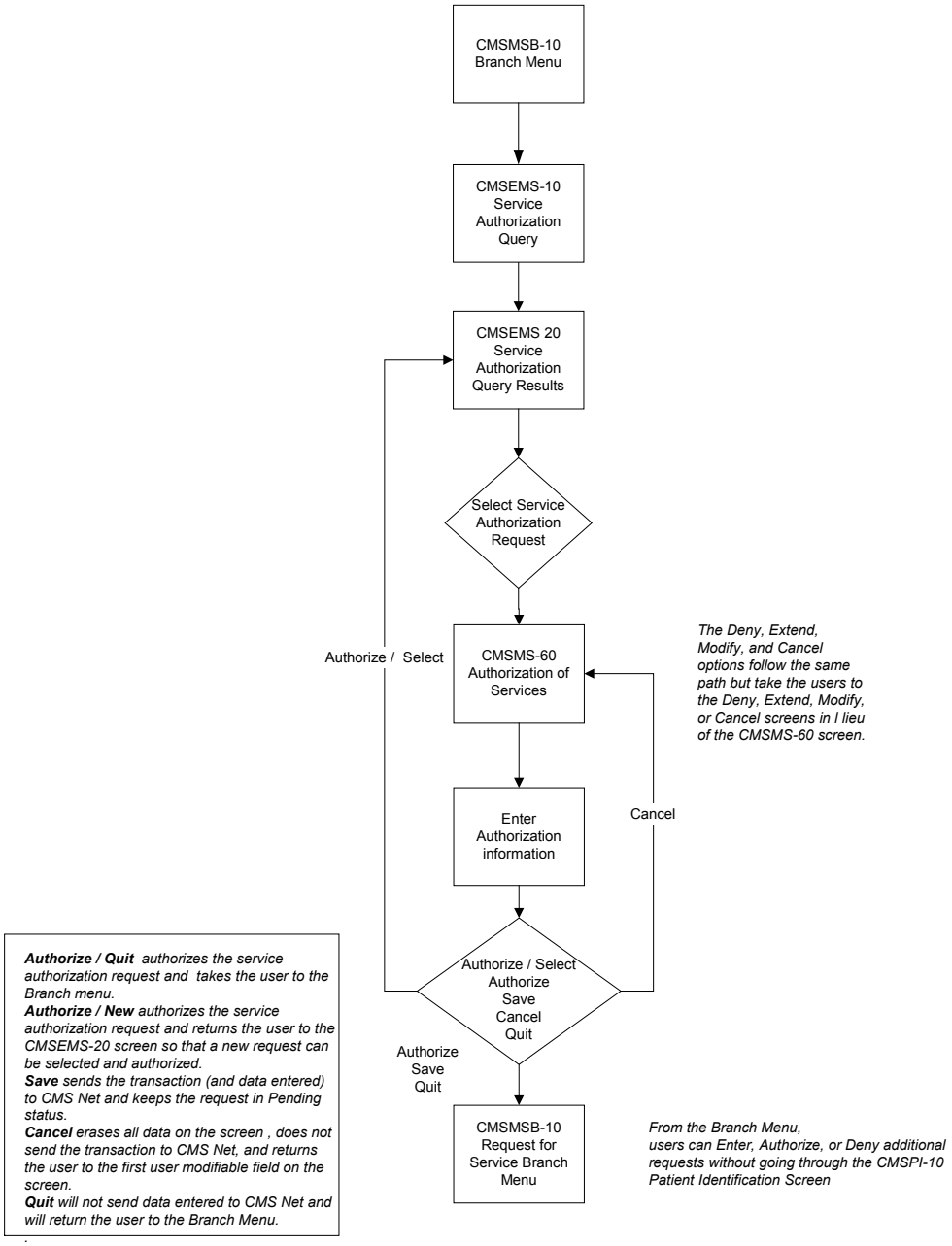


Figure 2.4, SAR Processing Screen Flow

Authorizing a SAR from the Branch Menu

AUTHORIZE SAR
From the Branch Menu



2.3 SAR PROCESSING SCREENS AND DATA DICTIONARIES

The subsections which follow present the basic screens used for processing SAR's. Each subsection presents a brief description of the screen, business rules which apply to the screen, an illustration of the screen, and a screen data dictionary. The screens are currently presented in a text-based format in order to present the data requirements for each screen. However, it is expected that these screens will be implemented with a graphical user interface (GUI).

2.3.1 CMSSMM-10, Service Authorization Request Main Menu

The CMSSMM-10 Main Menu provides access to all SAR functions. An illustration of the main menu is presented below.

Figure 2.1, Service Authorization Request Main Menu

```
        1234567890123456789012345678901234567890123456789012345678901234567890123456789
1       CMSNET              SERVICE AUTHORIZATION REQUEST MAIN MENU              CMSSMM-10
2
3
4
5       Select Option:
6
7       ()AUTHORIZE SAR                              ()MODIFY SAR
8       ()CANCEL SAR                                 ()PRINT AUTHORIZATIONS
9       ()CATEGORY OF SERVICE INQUIRY                ()PROCEDURE CODE INQUIRY
10      ()DENY SAR                                   ()PROVIDER INQUIRY
11      ()DENTAL PROCEDURE CODE INQUIRY              ()QUERY CMS NET
12      ()DENTAL CODE XREF LOOKUP
13      ()ENTER SAR
14      ()EXTEND SAR
15      ()FORMULARY FILE INQUIRY
16
17
18      [Quit]
19
20
21
22
23
24
```

Table 2-2 describes the functions available from the CMSSMM-10 Main Menu. The table identifies the menu option, presents a brief description of the option, and provides a reference to the section of this document which describes the function in greater detail.

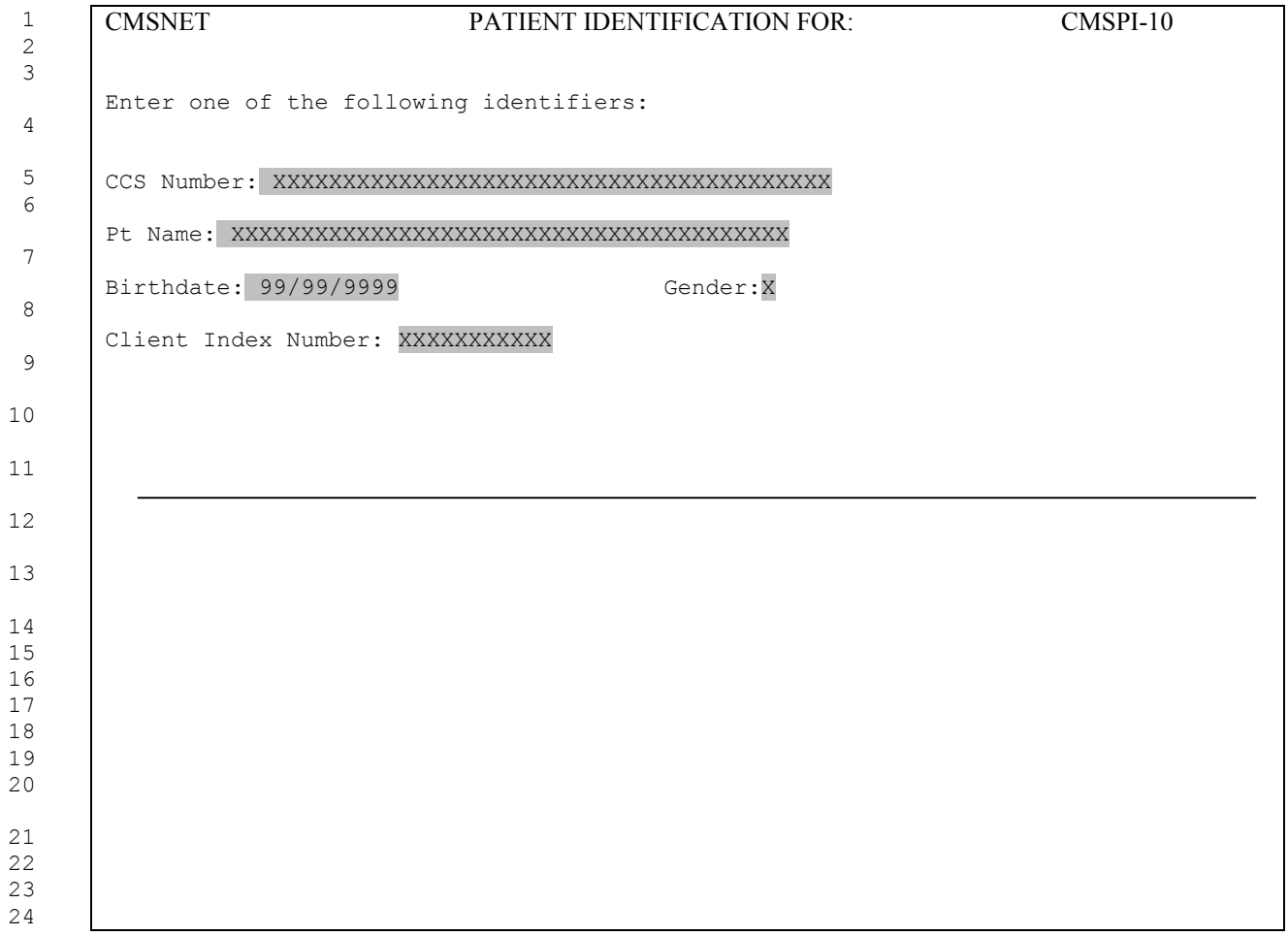
Table 2-2, Service Authorization Request Main Menu Functions

Menu Option	Description	Reference
Authorize SAR	Displays the screens for authorizing a SAR.	Section 2
Cancel SAR	Displays the screens for canceling an authorized SAR.	Section 2
Category of Service Inquiry	Displays the Category of Service Query screen series, which enables users to look up a specified category of service code.	Section 3
Deny SAR	Displays the screens for denying a SAR.	Section 2
Dental Procedure Code Inquiry	Displays the dental procedure code screen screen series, which enables users to look up a specified dental procedure code.	Section 3
Dental Code XRef Look Up	Displays the dental code cross reference look up screens, which display a table that cross reference the 3, 4, and 5 digit dental procedure codes.	Section 3
Enter SAR	Displays the screens for entering a SAR.	Section 2
Extend SAR	Displays the screens for extending a SAR.	Section 2
Formulary File Inquiry	Displays Drug Code look up screens, which enable users to look up a specified drug code.	Section 3
Modify SAR	Displays the screens for modifying a SAR.	Section 2
Print Authorizations	Displays the Print Authorized Request screen. Allows users to print SAR's within specified parameters.	Section 3
Procedure Code Inquiry	Displays the Procedure Code inquiry screens, which enables users to look up a specified procedure code.	Section 3
Provider Inquiry	Displays the Provider Inquiry screen, which enables user to look up a provider.	Section 3
Query CMS Net	Displays the CMS Net query screens which enable users to query CMS Net for a SAR.	Section 2

2.3.2 CMSPI-10, Patient Identification Screen

The CMSPI-10 patient Identification screen is illustrated below. *This screen has already been developed and is currently in production.* It is included in this document for reference purposes only because it is an important component of the SAR screen flow.

Figure 2.2, CMSPI-10 Patient Identification Screen



2.3.3 CMSSAR-10, Service Authorization Request Query Screen

The CMSSAR-10 screen is used to initiate a query of CMS Net. The screen includes the parameters which can be entered into CMS Net to narrow a search, and includes a header which identifies information on the client whose SAR's will be searched (the client would have already been chosen through the CMSPI Patient Identification screen).

2.3.3.1 Screen Reference Layout

Refer to Figure 2-3, CMSAR-10 Screen layout, for a pictorial representation of this screen.

Figure 2-3, CMSSAR-10 Screen

```
C      0        1         2         3         4         5         6         7         8
       12345678901234567890123456789012345678901234567890123456789012345678901234567890

 1     CMSNET          MEDICAL SERVICE AUTHORIZATION REQUEST QUERY              CMSSAR -10
 2     Pt Nm: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  CCS#: 9999999  CIN: 99999999X 9
 3     Gender: X  DOB: 99/99/9999  Lgl Co: XXXXXXXXXX  REG=XXX  MED=X  F/R=XXXXXXXXXXXX
       Pgrm Begin 99/99/9999 End 99/99/9999 CCS Elig Status:XXXXXXXXXXXXXXXXXXXX
 4
       Enter one of the Identifiers:
 5
 6
       All Requests: X
 7
       SAR Number: 99999999999  SAR Status: XXXXXXXXXXXX
 8
       Service Classification: XXXXXXXXXXXXXXX
 9
       Provider Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX    Provider Number: X99999999
10
       Service Period                Eligibility Period
11     Begin 99/99/9999              Begin 99/99/9999
       End   99/99/9999              End   99/99/9999
12
13
14
15
16
17
18
19
20
21
22
23
24
```

2.3.3.2 Screen Business Rules

The following business rules apply to the CMSSAR-10 Screen:

- This screen will be used to query for authorizations on CMS Net. It will not initiate a query of the SAF file.
- If a user places a Y in the All Requests field, CMS Net will display a list of all requests for the selected patient. The search can be narrowed by inputting at least one, or a combination of multiple entries in the remaining fields on the screen.
- Partial entries in either the Provider Name or Providor Number fields will render a pick list of matching providers in the PMF. Users will be able to select a provider from the list. After selecting the provider, the Provider Name and Provider Number fields will be automatically populated by CMS Net.
- If a user input field is left blank, all SAR's will be displayed subject to the entry in other fields. For example, if a provider name and number are entered, but the status field is left blank, CMS Net will return the SAR's with all statuses that are associated with the specified provider and selected client. If Pending is entered in the status field, then only Pending requests associated with the provider and client will be displayed.
- If a Service Period Begin Date is entered, a Service Period End date must also be entered.
- If an Eligibility Period Begin Date is entered, an Eligibility Period End date must also be entered.
- All user input fields will default to blank when this screen is initially displayed.
- Prior to initiating a search on this screen, the user must select a client on the CMSPI-10 Patient Identification screen.
- After selecting a patient, patient information will be displayed on a screen header. This information will be pulled from the eligibility / patient registration component of CMS Net.

2.3.3.3 Data Dictionary

Table 3-3 details each of the data fields that should be included on the CMSSAR-10 screen, along with their attributes.

Table 3-3, CMSSAR-10 Data Dictionary

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
2	*(header)* **PT Nm**	40 Alpha	N/A	Display Only	PATIENT NAME Patient Name from the Patient Registration component of CMS Net	
2	*(header)* **CCS #**	7 Numeric	N/A	Display Only	CCS NUMBER The patient's CCS number, assigned during the patient registration process.	
2	*(header)* **CIN**	11 Alpha / Numeric	N/A	Display Only	CIN The patient's statewide Client Index Number, assigned during the registration process.	
3	*(header)* **Gender**	1 Alpha	N/A	Display Only	GENDER The patient's gender, M (male) or F (female).	
3	*(header)* **DOB**	10 Numeric	N/A	Display Only	DATE OF BIRTH The patient's date of birth.	
3	*(header)* **Lgl Co**	10 Alpha	N/A	Display Only	LEGAL COUNTY The patient's legal county.	
3	*(header)* **Reg**	3 Alpha	N/A	Display Only	REGISTRATION STATUS The status of the patient's registration.	
3	*(header)* **MED**	1 Alpha	N/A	Display Only	MEDICAL ELIGIBILITY Indicates whether the patient has medical eligibility for the CCS program.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
3	*(header)* **F/R**	12 Alpha	N/A	Display Only	FINANCIAL / RESIDENTIAL ELIGIBILITY Indicates whether the patient has financial / residential eligibility for the CCS program.	
4	*(header)* **Prgm Begin Date**	10 Numeric	N/A	Display Only	PROGRAM BEGIN DATE The date that the patient's eligibility for the CCS program began.	
4	*(header)* **Pgrm End Date**	10 Numeric	N/A	Display Only	PROGRAM END DATE The date that patient's eligibility for the CCS program ends.	
4	*(heade)r* CCS Elig Status	20 Alpha	N/A	Display Only`	CCS ELIGIBILITY STATUS The overall status of the patient's CCS eligibility.	
9	All Requests	1 Alpha	Conditional	User Input	ALL REQUESTS Enter Y to print all requests for the selected patient. VALUES Defaults to blank. Field must be left blank if any other search criterion is selected. An entry in this field OR one of the other fields is required to narrow the search.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
11	Req Number	11 Numeric	Conditional	User Input	SAR NUMBER The number of a SAR a user wishes to search for. VALUES Users may enter full or partial SAR number of the provider to invoke a search of CMS Net. SAR numbers with that specific sequence will be indluced in the search.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
11	Req Status	9 Alpha	Conditional	User Input / Pick List	SERVICE REQUEST STATUS The status of the requests the user is searching for. The request will be chosen from a pick list. The following status will be included in the pick list: New – A SAR that has been initiated but not saved. Pending – A SAR that has been saved but which has not been authorized, denied, canceled, or modified. Authorized – A SAR that has been authorized using the CMSMS-60 screen. Denied – A SAR that has been denied using the CMSMS-70 screen. Canceled – A SAR that has been authorized and subsequently canceled using the CMSSAR-80 screen. Extended – A SAR that has been authorized and extended using the CMSSAR-85 screen. Modified – A SAR that has been authorized and the user has modified the authorization using the CMSSAR-90 screen.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
13	Service Classification	15 TBD	Conditional	User Input / Pick List	SERVICE CLASSIFICATION The classification of the SAR. VALUES TBD	
15	Provider Name	40 Alpha	Conditional	User Input / Pick List	PROVIDER NAME The Provider's full name. VALUES Selected from the Provider Master File. Users may enter full or partial name of the provider to invoke a search of the Provider Master File. The Provider Name can be selected from the list of names returned.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
15	Provider Number	9 Alpha / Numeric	Conditional	User Input / Pick List	PROVIDER NUMBER The identification number assigned to the Provider. The provider number will be selected from the Provider Master File. Users may enter full or partial number in order to invoke a search of the Provider Master File for the desired number. If a partial number has been entered, the user will be able to select the provider from a list of provider names and numbers returned. If a user enters a complete (rather than partial) and valid provider number, the system shall populate all fields on the screen with the provider's information.	
18	Service Period Begin	10 Numeric	Conditional	User Input	SERVICE PERIOD BEGIN The beginning date of the period covered by the SAR. The date must occur between the Prgm Begin and Prgm End dates. If a Service Begin Date in entered, a Service End Date must be entered before the search can be executed.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
19	Service Period End	10 Numeric	Conditional	User Input	SERVICE PERIOD END The ending date of the period covered by the SAR. The date must occur after the Service Begin Date and Prgm Date. The date cannot occur after the Prgm End date. If a Service End Date in entered, a Service Begin Date must be entered before the search can be executed.	
18	Eligibility Period Begin	10 Numeric	Conditional	User Input	ELIGIBILITY PERIOD BEGIN The first date of the client's eligibility period (program eligibility). If an eligibility period begin date is entered, an eligibility end date must be entered.	
19	Eligibility Period End	10 Numeric	Conditional	User Input	ELIGIBILITY PERIOD END The end date of the client's eligibility period (program eligibility). If an eligibility period begin date is entered, an eligibility period end date must also be entered.	

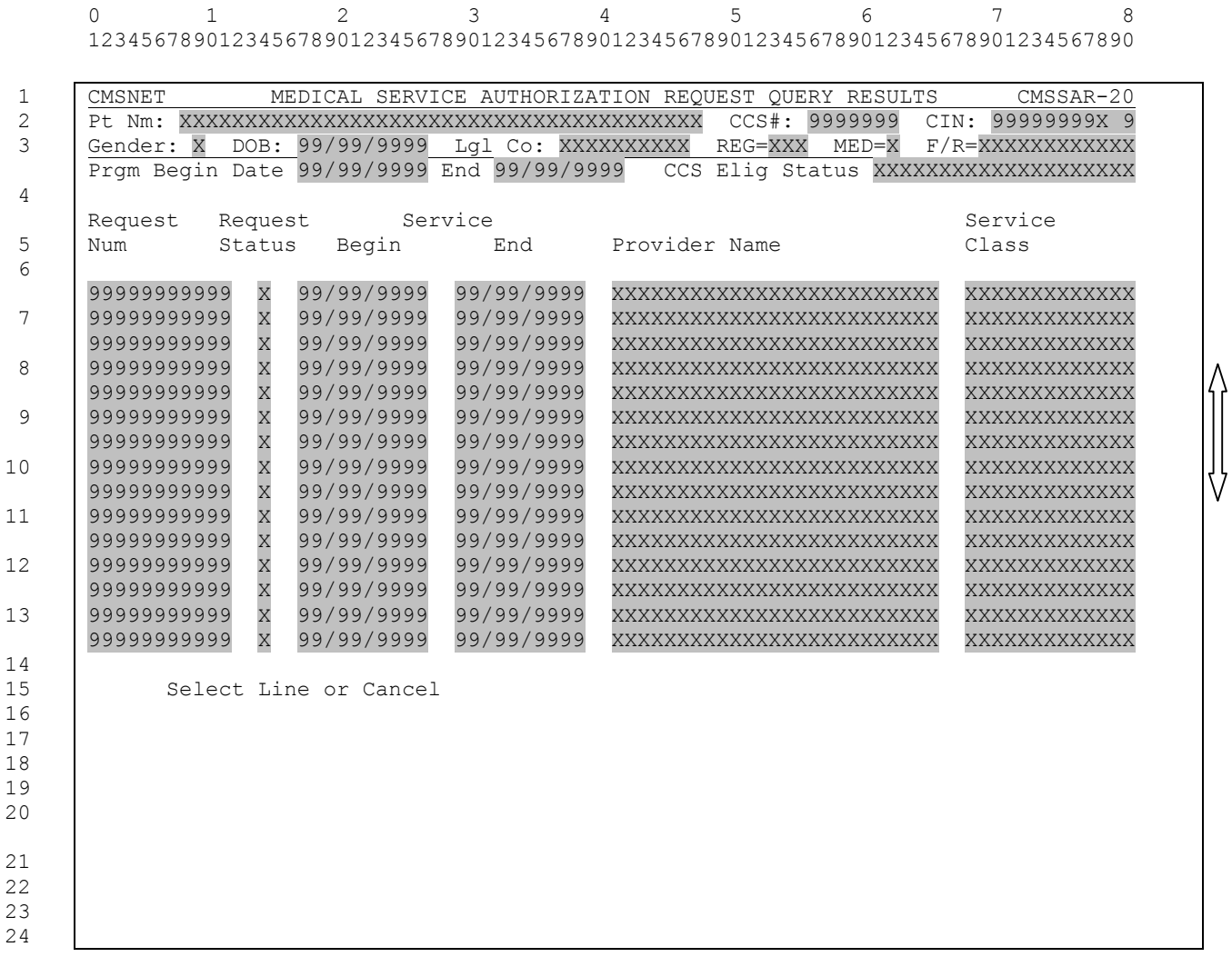
2.3.4 CMSSAR-20, Service Authorization Request Query Results

This screen presents the results of a successful CMS Net SAR query. It will be displayed after a user has initiated a query using the CMSSAR-10 screen and matching records have been found. Depending on the function initially selected from the CMSSMM-10 Main Menu, users will be able to select a SAR to view, print, authorize, deny, cancel, extend, or modify using the list of SAR's presented on this screen.

2.3.4.1 Screen Reference Layout

Refer to Figure 2-4, CMSAR-20 Screen layout, for a pictorial representation of this screen.

Figure 2-4, CMSSAR-20 Screen



2.3.4.2 Screen Business Rules

The following business rules apply to this screen:

- This screen shall display records from the CMS Net database (rather than the SAF).
- All records that fit the query parameters entered on the CMSSAR-10 screen will be displayed on this screen.
- All information on the screen will be display only.
- Users should be able to scroll the list of SAR's, select a SAR, and take a specified action (view, print, authorize, deny, cancel, extend, modify).

2.3.4.3 Data Dictionary

Table 3-4 details each of the data fields which should be included on the CMSSAR-20 screen, along with their attributes.

Table 3-4, CMSSAR-20 Data Dictionary

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
1-4	*(header)*	**N/A**	N/A	Display Only	HEADER Common header from the Patient Registration Screen. See the CMSSAR-10 screen.	
7	Request Number	11 Numeric	N/A	Display Only	REQUEST NUMBER 11 digit system generated number assigned to the SAR. See the CMSSAR-50 screen for business rules.	
7	Request Status	1 Alpha	N/A	Display Only	SERVICE REQUEST STATUS The status of the SAR. Values are: VALUES P=Pending A=Authorized D=Denied C=Canceled M=Modified E=Extended	
7	Service Period Begin	10 Numeric / Date	N/A	Display Only	SERVICE PERIOD BEGIN The beginning date of the period covered by the SAR.	
7	Service Period End	10 Numeric / Date	N/A	Display Only	SERVICE PERIOD END The ending date of the period covered by the SAR.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
7	Provider Name	40 Alpha	N/A	Display Only	PROVIDER NAME The Provider's full name	
7	Service Class	15 TBD	N/A	Display Only	SERVICE CLASSIFICATION The classification of the SAR. VALUES TBD	

2.3.5 CMSSAR-50, Service Authorization Request Entry

The CMSSAR-50 screen will be used to enter the details of a SAR. The screen is used to select a provider and enter the dates the SAR will be valid, services to be provided, and diagnosis information.

2.3.5.1 Screen Reference Layout

Refer to Figure 2-5, CMSAR-50 Screen layout, for a pictorial representation of this screen.

Figure 2-4, CMSSAR-50 Screen

```
         0         1         2         3         4         5         6         7         8
         12345678901234567890123456789012345678901234567890123456789012345678901234567890

1        CMSNET               SERVICE AUTHORIZATION REQUEST ENTRY                CMSSAR-50
2        Pt Nm: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  CCS#: 9999999  CIN: 99999999X 9
3        Gender: X  DOB: 99/99/9999  Lgl Co: XXXXXXXXXX  REG=XXX  MED=X  F/R=XXXXXXXXXXXX
4        Pgrm Begin Date99/99/9999 End 99/99/9999     CCS Elig StatusXXXXXXXXXXXXXXXXXXXX
5        Req Number:99999999999   Req Status:XXXXXXXX
6
7        Provider Name:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX Provider Num:X99999999
8        Service Begin Date:99/99/9999  Service End Date: 99/99/9999  Number of Days:999
9        Service Classification: XXXXXXXXXXXXXXX

10       Services Requested
11       Service Code  Description                                                Units  Quant
12       X9999999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       9999   9999
13       X9999999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       9999   9999
14       X9999999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       9999   9999
15       X9999999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       9999   9999
16       X9999999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       9999   9999
17       X9999999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       9999   9999
18       X9999999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       9999   9999
19
20       PrimDX:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
21       SecDX: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
22
23       Last Update By XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3   Date 99/99/9999
24
```

2.3.5.2 Screen Business Rules

The following business rules apply to this screen:

Client Eligibility

- Clients must have CCS eligibility in order to receive CCS services. The system should automatically check a client's eligibility based on the information in the CMS Net client eligibility component.
- The system should allow the entry of an authorization which is valid for up to a year. However, the system shall prevent the issuance of an authorization which extends beyond the client's CCS eligibility period (21st birthday or program end date).
- The client must have a CIN number assigned before a SAR can be generated.
- All authorizations will be specific to a single client.

Providers

- All providers, regardless of provider type, must be enrolled and in active status on the provider master file in order to be added to the authorization and selected to provide services.
- Providers will be chosen through a search of the provider master file. Users should have the ability to search the provider master file by inputting a partial provider name in the Provider Name field, or a partial provider number in the Provider Number field. The search will render a list of matching providers based on the search criteria. Both the Provider Name and Provider Number Field should be automatically populated once a provider is selected.
- The authorized provider must be the billing, rendering, or referring provider.
- The Provider must be selected before services can be entered (by user inputs in the Service Code, Description, Units, or Quant fields).
- The provider's category of service will determine the types of services the provider can provide and hence, the specific services which can be entered on the SAR. This includes the differentiation between medical and dental providers. Services that are not included in the provider's category of service cannot be entered on the SAR. This association will be made from the CMS Net tables (see Section 5).
- Only one provider will be allowed fowr one authorization. If another provider is desired, a separate authorization must be generated.

Special Care Centers

- Special care center authorizations will be issued to a specific special care center.
- The system will only allow the issuance of authorizations to special care centers which are approved (enrolled and paneled) by CCS.

- The system shall automatically check the provider master file to ensure that the special care center is authorized by CCS to provide services. The system shall prevent the issuance of an authorization to an unauthorized special care center.
- A single authorization shall be issued to cover special care centers. The authorization will authorize each member of the special care center to provide services within their category of service. The provider master file will associate special care centers and providers.
- Individual care providers must be associated with the special care center on the date that the services are rendered in order to receive payment for services. The provider's association with the special care center must be automatically verified before the claim is paid.

Selection / Entry of Services

- The system shall only allow services to be entered through the use of specific codes. The following codes shall be used to denote services:
    - Procedure Codes
    - Procedure Codes With Modifiers
    - Category of Service Codes
    - Accomodation Code
    - NDC Codes
    - HCPCS Codes
    - HCPCS Codes with modifier
    - Ancillary Codes
    - Medical Supplier Codes
    - Dental service codes

- Service codes shall be selected from a table or file which includes valid codes and prevents the use / selection of invalid or outdated codes.
- An authorization may include code specific services or categories of service.
- All service codes on an authorization must have an associated quantity.
- Category of service codes will always have a quantity of “1”
- The system shall allow CCS workers to enter a negotiated price for service codes. The negotiated price shall the current price for services on file and shall be the price paid.
- The system should provide a data element on the authorization that can override the legal county on the HAP file for the recipient. The only allowable entry to this field will be county code 59.
- The system shall prevent the entry of services on an authorization which do not fall within the provider’s scope of services.
- The system shall allow code specific authorizations to override any limitations on the category of service.
- The system shall allow procedure code specific authorizations to override any modifier limitations for that procedure.
- The system shall issue authorizations which can override the same limitations in CALPOS as a Medi-Cal TAR including but not limited to 6 prescription limits, end dated drugs, drugs not on the list of contract drugs, and code 1 restrictions.
- The system should not issue authorizations which will override a TAR-2 limitation on the formulary file.The system shall include a table which lists drugs which require a specific authorization.
- Services can be entered by entering a partial service code or description in the Service Code or Description fields. CMS Net will use these partial entries to search the code tables or files and provide users with a list of codes from which to select a service. The list of codes will be filtered based on the provider selected (e.g., codes that are not within the provider’s category of service will be automatically selected and not displayed for selection). CMS Net will list valid codes, and associate providers to codes, through a series of tables in CMS Net. Refere to Section 5 for additional information on CMS Net tables.
- Some dental procedures have separate 3, 4, and / or 5 digit codes (for the same procedure). Users will be allowed to enter a 3, 4, or 5 digit code for a dental service on the SAR. CMS Net should accept either of these codes for input into the SAR. A translation table will maintained which cross references the 3, 4, and 5 digit codes.
- Services on an authorization for dental services shall be tooth or frequency specific when appropriate.

- The system shall include a table which groups dental services into categories of service (similar to medical categories of service). Workers shall have the ability to authorize dental services by group.
- Up to 60 service codes may be entered on one SAR.
- The description field will default to the description field that is on the procedure table (refer to section 5 of this document for information on the procedure table).
- The quantity field is only available for procedure codes or NDC codes. The field will default to blank and cannot be updated when a category of service code is selected.
- Authorizations for inpatient hospital provider types shall be for a specific number of inpatient days only. The authorization will cover all services within the hospital's per deim rate.
- CMS Net will generate unique number for every request and will populate the Request Number (Req Number) field.
- The request number field is display only. The request number will be generated by CMS Net. The specific digits of the request number have not yet been determined, except that the first two digits of all CCS requests will be 97, and the last digit will be 0.
- The status field will display the last saved status of the SAR.

Dates of Service

- The Service Begin Date (the first date that the service can be rendered) is a required field and will default to blank.
- The Service Begin Date service can not occur before the Prgm Begin date (the first date that the client is eligible to receive program services).
- The Service Begin Date can not occur after the Prgm End Date.
- The Service End Date (the last date that services covered by the authorization can be rendered) will default to Blank.
- The Service End Date will generally not go beyond client's 21st birthday. However, under specific circumstances, users with the proper security level (expected to be one of the highest system security levels) may override this limitation.
- The Service End Date will not go beyond the Prgm End Date (the last date in the clients current eligibility period).
- The Service End Date can not occur before the Prgm End Date.
- The Number of Days field can be automatically calculated when the user enters the Service begin and end dates; alternately, users will be allowed to enter the Service Begin Date and the number of days, and the system will automatically calculate the Service End Date.
- The Number of Days field will not be automatically calculated for Inpatient Hospital provider types. For these provider types, the Number of Days field must be

manually input by the user. The number of days cannot exceed the total number of days between the Service Begin Date and Service End Date.

Other Business Rules

- The PrimDX field (primary diagnosis) will default to the primary diagnosis that is on the face sheet. User can enter another primary diagnosis in the PrimDX field.
- The SecDX field (secondary diagnosis) will default to the SecDX that is on the face sheet. Users can enter another secondary diagnosis in the SecDX field. However, the SecDX field is optional and may be left blank.

In addition to the above, the CMS E47 business rules for medical and dental service authorizations provide additional rules regarding the providers, their services, and the entry of services on a SAR. These business rules govern the issuance of SAR's and must also be incorporated into the E47 programming. The business rules are included in Appendices A and B of this document.

The above business rules contain frequent references to procedure, category of service and other codes. Refer to Section 5 of this document for additional information on the tables or files that are used to manage these codes.

2.3.5.3 Data Dictionary

Table 3-5 details each of the data fields which should be included on the CMSSAR-50 screen, along with their attributes.

Table 3-5, CMSSAR-50 Data Dictionary

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
1-4	*(header)*	N/A	N/A	Display only	HEADER Common header from the patient registration screens. See the CMSSAR-10 screen..	
5	Req Number	11 Numeric	N/A	System Generated Display Only	REQUEST NUMBER CCS requests will have a pre-fix of 97. GHPP will have a prefix of 99. Digits in spaces 3 through 10 must be defined.. 11th digit shall always be "0"	
5	Req Status	9 Alpha	N/A	Display Only System Generated	REQUEST STATUS Status of the SAR generated by the system. See the CMSSAR-10 screem.	
7	Provider Name	30 Alpha	N/A	User Input / CMS Net Table	PROVIDER NAME The Provider's full name **VALUES** Selected from the Provider Master File Users may enter full or partial name of the provider to invoke a search of the Provider Master File. The Provider Name can be selected from the list of names returned. Selection of a Provider Name in this field automatically add values to all remaining fields on the screen. CONDITIONS Either a Provider Name or Provider Number must be entered on this screen. If one of these values is entered, the other field will be automatically populated from the PMF.	

7	Provider Num	9 Alpha/Numeric	N/A	User Input / CMS Net Table	PROVIDER NUMBER **Selected from the Provider Master File** Users may enter full or partial number in order to invoke a search of the Provider Master File. If a partial number has been entered, the user will be able to select the provider from a list of provider names and numbers returned. If a user enters a complete (rather than partial) and valid provider number, the system shall populate all fields on the screen with the providers information. Selection of a Provider Number in this field will automatically add values to all remaining fields on the screen, including the Provider Name. CONDITIONS Either a Provider Name or Provider Number must be entered on this screen. If one of these values is entered, the other field will be automatically populated from the PMF.	
8	Service Begin Date	10 Numeric	Yes	User Input	SERVICE BEGIN DATE VALUES Users will be allowed to enter a value in the Service Begin Date field and the Number of Days, and the system automatically calculate the value of the Service End Date field. Users will be allowed to enter a value in the Service Begin Date field and the Service End Date field, and the system will automatically calculate the value of the Number of Days field.	

					For authorizations with a hospital provider type, the Number of Days field must always be manually input. The begin date will default to Blank. The date must occur between (and include) the Prgm Begin and Prgm End dates. CONDITIONS For authorizations with a hospital provider type, the Number of Days field must always be manually input.	
8	Service End Date	10 Numeric	Yes / Conditional	User Input or System Generated	SERVICE END DATE This field will default to blank. Service End Date can not occur after the Prgm End Date. Service End Date can not occur after the client's 21st birthday. CONDITIONS Users will be allowed to enter a value in the Service Begin Date field and the Number of Days field, and the system automatically calculate the value of the Service End Date field. Users will be allowed to enter a value in the Service Begin Date field and the Service End Date field, and the system will automatically calculate the value of the Number of Days field. If a user enters a valid Service End Date, the system shall calculate the number days between	

					the Service Begin Date and Service End Date and populate the Number of Days field. If the user enters a number of days, the system will calculate the value of the Service End Date field by calculating the sum of the Service Begin Date and the Number of Days. CONDITIONS For authorizations with a hospital provider type, the Number of Days field must always be manually input.	
8	Number Of Days	3 Numeric	Yes / Conditional	User Input or System Generated	NUMBER OF DAYS VALUES Users will be allowed to enter a value in the Service Begin Date field and the Number of Days, and the system automatically calculate the value of the Service End Date field. User will be allowed to enter a value in the Service Begin Date field and the Service End Date field, and the system will automatically calculate the value of the Number of Days field. CONDITIONS If a user enters a valid Service End Date, the system shall calculate the number days between the Service Begin Date and Service End Date and populate the Number of Days field. The number of days (calculated from the Service Begin Date) cannot exceed the Prgm End Date The number of days (calculated from the Service Begin Date) cannot exceed the clients 21st	

					birthday.	
9	Service Classification	15 TBD	N/A	User Input / CMS Net Table	SERVICE CLASSIFICATION The classification of the SAR. VALUES TBD	
12	Service Code	11 Alpha / Numeric (11 denotes the maximum number of characters, 2 is the minimum number. Length of code depends on code type).	Yes	User Input / CMS Net Tables	SERVICE CODE There will be 5 new CMS Net tables containing procedure codes, category of service codes, drugs codes, dental procedure codes, and a dental procedure code translation table. When the cursor lands on the Service Code Field, CMS Net should prompt the user to identify what type of code will b entered. Acceptable codes will be Procedure Code, Procedure Code with Modifier, Category of Service, Drug or Dental codes. After selecting the type of code, users will be able to scroll the appropriate table for the code they wish to enter. Users can also enter a code by directly typing in a valid code without invoking the pop up menu. CMS Net should automatically determine whether the code is valid. The user enters the procedure code, category of service code, NDC, or dental service code. The services that can be entered will depend on the provider type, request type, and date of request (for a code which is valid on the day of the request). Other edits may apply, such as age limitations.	

					Dental procedures may have 3,4, and / or 5 digit codes. CMS Net will accept either code. A new table must be created which will translate / cross reference the codes. User can input up to 60 service lines. If additional services are required a new SAR will have to be entered or if a different provider is being authorized. Users should be able to type a partial or full code or scroll and select from the table. CONDITIONS If a physician provider type is selected and not EPSDT-SS, pick list choices will be Procedure Code, Procedure Code plus Modifier, and Category of Service codes. If a physician provider type is selected and is EPSDT, pick list choices will be Procedure Code and Procedure Code plus Modifier. If a Special Care Center provider type is selected, pick list choices will be Category of Service. Users should be able to enter valid 3, 4, or 5 digit codes for the same service. CMS Net will utilize the dental procedure translation table to automatically cross reference different codes for the same procedure.	
12	Description	50 Alpha / Numeric	Yes	User Input / CMS Net Tables	SERVICE DESCRIPTION See above rules for entering service codes. Searches of the appropriate code table	

					(procedure, category of service, dental, or drug code table) will be allowed by entering full or partial description in this field.	
12	Units	Numeric	Conditional	User Input	SERVICE UNITS The number of units that are being authorized. The default will be 001. Units for category of service codes will always be 001. Users will not be able to change the number of units for category of service codes. This field will be required for procedure and NDC codes.	
12	Quant	Numeric	Conditional	User Input	SERVICE QUANTITY The number of items within the unit. Field defaults to 1. (CMS Net should automatically enter leading zeros if necessary). The field can not be accessed when a category of service code is being authorized.	
21	PrimDX:	72 Alpha / Numeric	Yes	User Input	PRIMARY DIAGNOSIS Primary Diagnosis Name and ICD-9 code from File 46 of CMS Net. This value defaults to the value on the face sheet. Users will have the ability overwrite this filed with a narrative description.	

22	SecDX:	72 Alpha / Numeric	Optional	User Input	SECONDARY DIAGNOSIS 2nd Diagnosis Name and ICD-9 code from File 46 of CMS Net. This value defaults to the value on the face sheet. Users will have the ability overwrite this field with a narrative description.	
24	Last Update By	Alpha 30	Display Only	N/A	LAST UPDATE BY Displays the last user's name who modified any data based on the user's user ID.	
24	Date	10	Display Only	N/A	DATE Displays the date of the last change.	

2.3.6 CMSSAR-60, Authorization of Services

This screen will be used to authorize services entered on the CMSSAR-50 screen.

2.3.6.1 Screen Reference Layout

Refer to Figure 2-6, CMSAR-60 Screen layout, for a pictorial representation of this screen.

Figure 2-6, CMSSAR-60 Screen

```
         0         1         2         3         4         5         6         7         8
         12345678901234567890123456789012345678901234567890123456789012345678901234567890

1        CMSNET                     AUTHORIZATION OF SERVICES                     CMSSAR-60
2        Pt Nm: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  CCS#: 9999999  CIN: 99999999X 9
3        Gender: X  DOB: 99/99/9999  Lgl Co: XXXXXXXXXX  REG=XXX  MED=X  F/R=XXXXXXXXXXXX
4        Prgm Begin Date99/99/9999 End99/99/9999    CCS Elig Status: XXXXXXXXXXXXXXXXXXXX
5                                         *AUTHORIZATION*
6        Req Number:99999999999   Req Status:XXXXXXXX Date Authorized:99/99/9999
7        Authorized By:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
8        Funding Source:XXXXXXXXXX  EPSDT-SS:X  County: XXXXXXXXXXXXXX
9        Service Classification: XXXXXXXXXXXXXXX
         Provider Name:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   Provider Num:X99999999
10       Service Begin Date:99/99/9999  Service End Date: 99/99/9999  Number of Days:999
11
12       Services Authorized
13       Service Code Description                                       Units  Quant  Amt
14       X9999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999   9999   99999.99
15       X9999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999   9999   99999.99
16       X9999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999   9999   99999.99
17       X9999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999   9999   99999.99
18       X9999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999   9999   99999.99
19
20       PrimDX:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
21       SecDX: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
22
23       Last Update By XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3   Date 99/99/9999
24
```

2.3.6.2 Screen Business Rules

The following business rules apply to this screen:

- Clients must have CCS eligibility in order to receive authorized services.
- The ability to authorize requests is subject to a user's authority and system security level.
- The Authorized By field is required. In order to populate this field, users should be able to select a name by scrolling a list of names based on the CMS Net user file.
- Funding source (diagnosis, treatment, Healthy Families, MTU) is a required field.
- The County code will default to the client's current legal county from the patient registration face sheet. CMS staff will be able to override this indicator with a county code 59. 59 will be the only allowable change to this field. The ability to make this change will be based on the user's security level (e.g., not all users will be able to change the county code). Security levels and their associated functions have not yet been defined.
- Category of service codes will not be allowed for EPSDT authorizations. If a category of service code has been entered, CMS Net will display an error message and take the user back to the CMSMS-50 screen. The cursor will land on the field with the erroneous category of service codes and the user will be required to with either delete the code or enter a new code. After these steps are taken, the user will be taken back to the CMSMS-60 screen.
- The price field will cannot be modified by the user unless the SAR is EPSDT-SS.
- Some drugs will require a specific authorization. The list of these drugs is presented Section 5, Table and File Maintenance.
- All user modifiable fields on this screen will default to the value that is currently stored on CMS Net and which were entered on previous screens.

2.3.6.3 Data Dictionary

Table 3-6 details each of the data fields which should be included on the CMSSAR-60 screen, along with their attributes.

Table 3-6, CMSSAR-60 Data Dictionary

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
1	*(header)*	N/A	N/A	Display only	HEADER Common header from the Patient Registration Screen. See the CMSSAR-10 screen.	
6	Req Number	11 Numeric	N/A	Display Only	REQUEST NUMBER Refer to the CMSSAR-50 screen.	
6	Req Status	10 Alpha	N/A	Display Only	REQUEST STATUS Refer to the CMSSAR-50 screen.	
6	Date Authorized	Numeric	N/A	Display Only	DATE AUTHORIZED The date the SAR is authorized. Defaults to “today’s date”.	
7	Authorized By	40 Alpha	Yes	User Input	AUTHORIZED BY Name of the user who authorized the request. Users shall have the ability populate this field by scrolling and selecting from a name list of names based on the CMS Net user table.	
8	Funding Source	9 Alpha	Yes	User Input Table resides in CMS NET #	FUNDING SOURCE VALUES Diagnosis, Treatment, Healthy Families, MTU	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
8	EPSDT-SS	1 Alpha	Yes	User Input	EPSDT- SS This field designates whether the authorization is for an EPSDT Supplemantal Service. CONDITIONS This field defaults to N. However, the field will default to Y (Yes) if the client is MediCal eligible and the provider is a Special Care Center. All service authorizations with an Y in this field must be procedure code or NDC code specific. Category of service codes will not be allowed for EPSDT authorizations. If a category of service code has been entered, CMS Net will display an error message and the cursor will land on the field with the erroneous category of service codes. The user will then be required to either delete category of service code or enter a new code (which is not a category of service code).	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
8	County	14 Alpha	Yes / Conditional	User Input or System Generated	COUNTY The client's legal county. The county will default to the value on the client's face sheet. Other than the value on the client's face sheet, the only allowable change to this field is to change the county to county code "59". County names should be displayed by their alpha names rather than their numeric codes. For processing purposes, CMS Net may need a table that translates the county names to their numeric codes.	
9	Service Classification	15 TBD	Conditional	User Input / Pick List	SERVICE CLASSIFICATION The classification of the SAR. VALUES TBD	
10	Provider Name	40 Alpha	N/A	Display Only	PROVIDER NAME Refer to CMSSAR-50 screen	
10	Provider Num	9 Alpha / Numeric	N/A	Display Only	PROVIDER NUMBER Refer to CMSSAR-50 screen.	
11	Service Begin Date	10 Numeric	Yes / Conditional	User Input or System Generated	SERVICE BEGIN DATE Refer to CMSSAR-50 screen.	
11	Service End Date	10 Numeric	Yes / Conditional	User Input or System Generated	SERVICE END DATE Refer to CMSSAR-50 screen.	
11	Number Of Days	3 Numeric	Yes / Conditional	User Input or System Generated	NUMBER OF DAYS Refer to CMSSAR-50 screen.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
14	Service Code	11 Alpha / Numeric	Yes	User Input	SERVICE CODE Refer to the CMSSAR-50 screen. Field can be changed by users.	
14	Description	47 Alpha / Numeric	Yes	User Input	SERVICE DESCRIPTIONS Refer to the CMSSAR-50 screen.	
14	Units	4 Numeric	Yes	User Input	SERVICE UNITS Refer to the CMSSAR-50 screen.	
14	Quant	4 Numeric	Yes	User Input	SERVICE QUANTITY Refer to the CMSSAR-50 screen.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
14	Amt	8 Numeric	Conditional	System Generated / User Input	SERVICE AMOUNT The price of the service, derived from the files with the procedure, category of service, and drug files. Field will default to blank if there is not a price on file. Field will be populated by the price on file if a price is present. Users can leave this field blank. The field will not be accessed when a category of service is being authorized and will default to 0. This field can not be updated by the user and is display only if there is a price on the table. User may input a negotiated price if there is no price on file. The price field will not be accessible unless it is an EPSDT-SS request. Users will be able override this field and input a negotiated price, subject to the user's security level. This field will not be displayed for dental codes.	
10	PrimDX	70 Alpha / Numeric	Yes	User Input	PRIMARY DIAGNOSIS Refer to CMSSAR-50 screen.	
11	SecDX	70 Alpha / Numeric	No	User Input	SECONARY DIAGNOSIS Refer to CMSSAR-50 screen.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
19	Last Update By	Alpha 30	N/A	Display Only	LAST UPDATE BY Displays the last user's name who modified any data. Based on the users system ID.	
20	Date	10	N/A	Display Only	DATE Displays the date of the last change.	

2.3.7 CMSSAR-70, Denial of Services

This screen is used to deny services entered on the CMSSAR-50 screen.

2.3.7.1 Screen Reference Layout

Refer to Figure 2-7, CMSAR-70 Screen layout, for a pictorial representation of this screen.

Figure 2-7, CMSSAR-70 Screen

2.3.7.2 Screen Business Rules

The following business rules apply to this screen:

- The Denied By field is required. Users should be able to scroll a list of names based on the CMS Net user file and select a name to populate this field. The name selected could be the user who is currently logged onto CMS Net and working with the SAR, or another CMS staff person.
- The Request must be in Pending status to be denied using this screen. Previously authorized requests can be canceled using the Cancel Request option on the CMSSMM-10 screen.
- The ability to deny requests is subject to a user's authority and system security level.

2.3.7.3 Data Dictionary

Table 3-7 details each of the data fields which should be included on the CMSSAR-70 screen, along with their attributes.

Table 3-7, CMSSAR-70 Data Dictionary

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
1-4	*(header)*	N/A	N/A	Display Only	HEADER Common header from the Patient Registration Screen. See the CMSSAR-10 screen.	
6	Request Number	11 Numeric	N/A	Display Only	REQUEST NUMBER Refer to CMSSAR-50 screen.	
6	Date Denied	8 Date	N/A	Display Only	DATE DENIED This date defaults to today's date.	
7	Denied By	40 Alpha	Yes	User Input	DENIED BY Name of the user who denied the request. Users shall have the ability to scroll and select a name from CMS Net user table.	
7	Eff Date	8 Date	Yes	User Input	EFFECTIVE DATE The date that the denial shall be effective.	
8	Service Classification	15 TBD	Yes	User Input / Pick List	SERVICE CLASSIFICATION The classification of the SAR. VALUES TBD	
9	Provider Name	70 Alpha / Numeric	N/A	Display Only	PROVIDER NAME Refer to the CMSSAR-50 screen.	
9	Provider Num	9 Alpha / Numeric	N/A	Display Only	PROVIDER NUMBER Refer to the CMSSAR-50 screen..	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
10a	Service Begin Date	10 Numeric	Yes	User Input	SERVICE BEGIN DATE Refer to CMSSAR-50 screen.	
10	Service End Date	10 Alpha/Numeric	Yes	User Input	SERVICE END DATE Refer to CMSSAR-50 screen.	
10	Number of Days	3 Numeric	Yes	User Input	NUMBER OF DAYS Refer to CMSSAR-50 screen.	
12	Denial Reason	79 x 5 Lines Alpha	Yes	User Input	DENIAL REASON Free text field indiciating the reason for the denial.	
20	PrimDX	70 Alpha / Numeric	Yes	User Input	PRIMARY DIAGNOSIS Refer to CMSSAR-50 screen.	
21	SecDX	70 Alpha / Numeric	No	User Input	SECONARY DIAGNOSIS Refer to CMSSAR-50 screen.	
23	Last Update By	30 Alpha	N/A	Display Only	LAST UPDATE BY Displays the last user's name who modified any data.	
23	Date	10	N/A	Display Only	DATE Displays the date of the last change.	

2.3.8 CMSSAR-80, Cancellation of Services

This screen will be used to cancel a SAR.

2.3.8.1 Screen Reference Layout

Refer to Figure 2-8, CMSAR-70 Screen layout, for a pictorial representation of this screen.

Figure 2-8, CMSSAR-80 Screen

```
      0        1         2         3         4         5         6         7         8
      12345678901234567890123456789012345678901234567890123456789012345678901234567890

 1    CMSNET                          CANCELLATION OF SERVICES                    CMSSAR-80
 2    Pt Nm: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  CCS#: 9999999  CIN: 99999999X 9
 3
      Gender: X  DOB: 99/99/9999  Lgl Co: XXXXXXXXXX  REG=XXX  MED=X  F/R=XXXXXXXXXXXX
 4    Pgrm Begin Date 99/99/9999 End 99/99/9999 CCS Elig Status XXXXXXXXXXXXXXXXXXXX
                                  *CANCELLATION*
 5    Request Number: 999999999999   Request Status:XXXXXXXX  Date Canceled: 99/99/9999
 6    Approved By: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
      Funding Source:XXXXXXXXXX     County: XXXXXXXXXXXXXX
 7    Service Classification: XXXXXXXXXXXXXXX
      Provider Name:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX Provider Num:X99999999
 8    Service Begin Date:99/99/9999  Service End Date:99/99/9999   Number of Days:999

 9    Reason for Cancellation
      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
10    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
11    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
12
      PrimDX:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
13    SecDX: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

14
15    Last Update By XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3    Date 99/99/9999
16
17
18
19
20

21
22
23
24
```

2.3.8.2 Screen Business Rules

The following business rules apply to this screen:

- SAR's that are in Pending, Authorized, Modified, or Extended status can be canceled.
- The Approved By field will be used to designate the individual who approved cancellation of the SAR. This could be the individual who is currently logged onto CMS Net and is working with the SAR, or another CMS staff person. Users should be able to select a name to populate this field by scrolling a list of names based on the CMS Net user file.
- Editing the Date Cancelled field will cancel the authorization effective the date entered. The entry in the Date Cancelled field must occur before the date in the Service End Date field.
- The ability to cancel requests is subject to a user's authority and system security level.
- Only SAR's which are in Pending, Authorized, Modified, or Extended status can be cancelled. New, or Pending SAR's should be denied, with clarifying comments added to the narrative.

2.3.8.3 Data Dictionary

Table 3-8 details each of the data fields which should be included in the CMSSAR-80 screen, along with their attributes.

Table 3-8, CMSSAR-80 Data Dictionary

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
1-4	*(header)*	N/A	Yes	Display only	HEADER Common header from the Patient Registration Screen. See the CMSSAR-10 screen.	
6	Request Number	11 Numeric	N/A	Display Only	REQUEST NUMBER See the CMSSAR-10 screen.	
6	Request Status	10 Alpha	N/A	Display Only	REQUEST STATUS See the CMSSAR-10 screen.	
6	Date Canceled	9 Date	Yes	User Input	DATE CANCELED The date that the SAR is canceled by the user. Defaults to today's date. The entry in the Date Canceled field must occur before the origional date in the Service End Date field. The Service End Date field should be automatically updated by CMS Net to equal the Date Canceled field once a value for this field is selected. The updated Service End Date will be sent to the SAF.	
7	Approved By	40 Alpha	Yes	User Input	CANCELLATION APPROVED BY Name of person who approved the cancellation. Users shall have the ability to populate this filed by scrolling and selecting a name from the CMS Net user table.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
8	Funding Source	9 Alpha	N/A	Display Only	FUNDING SOURCE Refer to the CMSSAR-60 screen.	
8	County	14 Alpha	N/A	Display Only	COUNTY Refer to the CMSSAR-60 screen.	
9	Service Classification	15 TBD	N/A	Display Only	SERVICE CLASSIFICATION The classification of the SAR. VALUES TBD	
10	Provider Name	70 Alpha / Numeric	N/A	Display Only	PROVIDER NAME Refer to the CMSSAR-50 screen.	
10	Provider Num	9 Alpha / Numeric	N/A	Display Only	PROVIDER NUMBER Refer to the CMSSAR-50 screen..	
11	Service Begin Date	10 Date	N/A	Display Only	SERVICE BEGIN DATE Refer to the CMSSAR 50 screen.	
11	Service End Date	10 Date	N/A	Display Only, Updated to equal the Date Canceled field.	SERVICE END DATE Refer to the CMSSAR 50 screen. CMS Net should automatically change the value of the Service End Date field to equal the value of the Date Canceled when an authorization is canceled.	
11	Number Of Days	3 Numeric	N/A	Display Only	NUMBER OF DAYS Refer to the CMSSAR 50 screen.	
13	Reason for Cancellation	79 x 5 Lines	Yes	User Input	REASON FOR CANCELLATION Free text field	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
20	PrimDX:	72 Alpha Numeric	N/A	Display Only	PRIMARY DIAGNOSIS Refer to CMSSAR-50 screen.	
21	SecDX	70 Alpha / Numeric	N/A	Display Only	SECONARY DIAGNOSIS Refer to CMSSAR-50 screen.	
24	Last Update By	Alpha 30	N/A	Display Only	LAST UPDATE BY Displays the last user's name who modified any data.	
24	Date	10 Date	N/A	Display Only	DATE Displays the date of the last change.	

2.3.9 CMSSAR-85, Extension of Services

This screen will be used to extend the dates that a SAR is valid.

2.3.9.1 Screen Reference Layout

Refer to Figure 2-9, CMSAR-85 Screen layout, for a pictorial representation of this screen.

Figure 2-9, CMSSAR-85 Screen

```
0        1         2         3         4         5         6         7         8
12345678901234567890123456789012345678901234567890123456789012345678901234567890

  CMSNET                      EXTENSION OF SERVICES                      CMSSAR-85
Pt Nm: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  CCS#: 9999999  CIN: 99999999X 9

Gender: X  DOB: 99/99/9999  Lgl Co: XXXXXXXXXX  REG=XXX  MED=X  F/R=XXXXXXXXXXXX
Pgrm Begin Date 99/99/9999 End 99/99/9999 CCS Elig Status XXXXXXXXXXXXXXXXXXXX
                                  *EXTENSION*
Req Number:99999999999   Req Status:XXXXXXXX Date Extended:99/99/9999
Approved By:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Funding Source:XXXXXXXXXX  EPSDT-SS:X  County: XXXXXXXXXXXXXX
Service Classification: XXXXXXXXXXXXXXX
Provider Name:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX Provider Num:X99999999
Service Begin Date:99/99/9999  Service End Date: 99/99/9999  Number of Days:999

Services Authorized
Service Code Description                                     Units   Quant  Amt
X9999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999    9999   99999.99
X9999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999    9999   99999.99
X9999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999    9999   99999.99
X9999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999    9999   99999.99
X9999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999    9999   99999.99

PrimDX:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
SecDX: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Last Update By XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3      Date 99/99/9999
```

2.3.9.2 Screen Business Rules

The following business rules apply to this screen:

- An “extension” of an authorization is defined as extending the service end date of the request. This can be accomplished by changing the Service End Date field or Number of Days field on the CMSEMS-85 screen. If a user enters a value in either the Service End Date field or Number of Days field fields, the system shall automatically calculate the value of the remaining field.
- Extended authorizations will be assigned a new authorization number and all of the data elements listed in the Authorize transaction for the newly extended authorization will be sent to the SAF. The Service Begin Date for the extended authorization will be the day after the service end date of the original authorization. This date will be automatically calculated by CMS Net. The original authorization (which was extended) will subsequently remain in effect until its service end date occurs.
- Authorizations can be extended any number of times (e.g., an authorization in Extended status can be extended again).
- In order to be extended, a request must be in Authorized, Extended, or Modified status.
- The Date Extended field will default to blank and must be inputed by the user.
- The Extended By field is required. Users will be able select a value for this field by scrolling a list of names based on the CMS Net user file.
- Users will generally be prohibited from entering a new service end date which occurs after the Program End date or the client’s 21st birthday, unless they have the proper security level.

2.3.9.3 Data Dictionary

Table 3-8 details each of the data fields which should be included in the CMSSAR-80 screen, along with their attributes.

Table 3-8, CMSSAR-85 Data Dictionary

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
1-4	*(header)*	N/A	N/A	Display only	HEADER Common header from the Patient Registration Screen. See the CMSSAR-10 screen.	
6	Req Number	11 Numeric	N/A	Display only	REQUEST NUMBER See the CMSSAR-10 screen.	
6	Req Status	10 Alpha	N/A	Display Only	REQUEST STATUS See the CMSSAR-10 screen..	
6	Date Extended	10 date	Yes	User Input	DATE EXTENDED The date the extension is authorized. Defaults to today's date.	
7	Approved By	Alpha	Yes	User Input	EXTENSION APPROVED BY Name of the person who approved the extension. Users shall have the ability to populate this field by scrolling the CMS Net user table and selecting a name from the table..	
8	Funding Source	9 Alpha	Yes	Display Only	FUNDING SOURCE Refer to the CMSSAR-60 screen.	
8	EPSDT-SS	1 Alpha	Yes	Display Only	EPSDT-SS This field designates whether the authorization is for an EPSDT-SS. Refer to the CMSSAR-70 screen.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
8	County	14 Alpha	Yes / Conditional	Display Only	COUNTY Refer to the CMSSAR-60 screen.	
9	Service Classification	15 TBD	Conditional	Display Only	SERVICE CLASSIFICATION The classification of the SAR. VALUES TBD	
10	Provider Name	70 Alpha / Numeric	N/A	Display Only	PROVIDER NAME Refer to the CMSSAR-50 screen.	
10	Provider Num	9 Alpha / Numeric	N/A	Display Only	PROVIDER NUMBER Refer to the CMSSAR-50 screen..	
11	Service Begin Date	10 Date	N/A	Display Only / System Generated	SERVICE BEGIN DATE The beginning date that the authorization will be effective. This date will be automatically generated by the system and shall default to the day after the origional authorization was set to expire.	
11	Service End Date	10 Date	Yes	User Input / Conditional	SERVICE END DATE Refer to the CMSSAR-50 screen.	
11	Number of Days	3 Numeric	Yes	User Input / Conditional	NUMBER OF DAYS Refer to the CMSSAR-50 screen.	
9	EPSDT-SS	1 Alpha	Yes	Display Only	EPSDT-SS This field designates whether the authorization is for an EPSDT-SS. Refer to the CMSSAR-70 screen.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
14	Service Code	11 Alpha / Numeric	N/A	Display Only	SERVICES The service code entered on the CMSSAR-50 screen.	
14	Description	Alpha / Numeric	N/A	Display Only	SERVICE DESCRIPTIONS The service description entered on the CMSSAR-50 screen.	
14	Units	4 Numeric	N/A	Display Only	SERVICE UNITS The number of units entered on the CMSSAR-50 screen.	
14	Quantity	4 Numeric	N/A	Display Only	SERVICE QUANTITY The service quantity entered on the CMSSAR-50 screen.	
14	Amount	8 Numeric	N/A	Display Only	SERVICE AMOUNT Refer to the CMSSAR-60 screen.	
21	PrimDX	70 Alpha / Numeric	N/A	Display Only	PRIMARY DIAGNOSIS The primary diagnosis from the patients face sheet.	
22	SecDX	70 Alpha / Numeric	Yes	Display Only	SECONARY DIAGNOSIS Refer to CMSSAR-50 screen.	
24	Last Update By	Alpha 30	N/A	Display Only	LAST UPDATE BY Displays the last user's name who modified any data.	
24	Date	10	N/A	Display Only	DATE Displays the date of the last change.	

2.3.10 CMSSAR-90, Modification of Services

This screen will be used to modify the services on an authorization.

2.3.10.1 Screen Reference Layout

Refer to Figure 2-10, CMSAR-90 Screen layout, for a pictorial representation of this screen.

Figure 2-10, CMSAR-90 Screen

```
          0        1         2         3         4         5         6         7         8
          12345678901234567890123456789012345678901234567890123456789012345678901234567890

1         CMSNET              SERVICE AUTHORIZATION REQUEST MODIFICATION             CMSEMS-90
2         Pt Nm: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  CCS#: 9999999  CIN: 99999999X 9
3         Gender: X  DOB: 99/99/9999  Lgl Co: XXXXXXXXXX  REG=XXX  MED=X  F/R=XXXXXXXXXXXX
4         Prgm Begin Date99/99/9999 End99/99/9999    CCS Elig Status: XXXXXXXXXXXXXXXXXXXX
5                                  *AUTHORIZATION*-Modified
6         Req Number:99999999999   Req Status:XXXXXXXX     Date Modified:99/99/9999
7         Approved By:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
8         Funding Source:XXXXXXXXXX  EPSDT-SS:X  County: XXXXXXXXXXXXXX
9         Service Classification: XXXXXXXXXXXXXXX
          Provider Name:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX Provider Num:X99999999
10        Service Begin Date:99/99/9999  Service End Date: 99/99/9999  Number of Days:999
11
12        Services Authorized
13        Service Code Description                                          Units  Quant  Amt
14        X9999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999   9999   99999.99
15        X9999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999   9999   99999.99
16        X9999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999   9999   99999.99
17        X9999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999   9999   99999.99
18        X9999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999   9999   99999.99
19
20        PrimDX:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
21        SecDX: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
22
23        Last Update By XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3     Date 99/99/9999
24
```

2.3.10.2 Screen Business Rules

The following business rules apply to this screen:

- The primary purpose of this screen is to correct errors or omissions in a SAR, e.g. to correct a mistake. This screen should not be used to change an authorization based on a change in the requested services due to changes in the patient's treatment plan. If a change in the requested services due to a change in patient's treatment plan is necessary, the original authorization should be canceled and a new SAR should be generated.
- At least one user changeable field must be modified on this screen to change the status to Modified.
- The provider can not be modified using this screen. If a different provider is required, the existing request must be canceled and a new request must be opened.
- Only the Service Code, Quantity or Units field can be modified.
- Authorizations which are in Extended status cannot be modified.
- All fields will default to the values currently stored in CMS Net for the service authorization, with the exception of the Date Modified field. This field will default to blank.
- The ability to modify authorizations is subject to a user's authority and system security level.

2.3.10.3 Data Dictionary

Table 3-9 details each of the data fields that should be included in the CMSSAR-80 screen, along with their attributes.

Table 3-10, CMSSAR-90 Data Dictionary

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
1-4	*(header)*	N/A	N/A	Display only	HEADER Common header from the Patient Registration Screen. See the CMSSAR-10 screen.	
6	Req Number	11 Numeric	N/A	Display only	REQUEST NUMBER Refer to the CMSSAR-10 screen.	
6	Req Status	10 Alpha	N/A	Display Only	REQUEST STATUS Refer to the CMSSAR-10 screen.	
6	Date Modified	10 date	N/A	Display Only	DATE EXTENDED The date the extension is authorized. Defaults to today's date.	
7	Approved By	Alpha	Yes	User Input	EXTENSION APPROVED BY Name of the person who approved the extension. Users shall have the ability to populate this field by scrolling the CMS Net user table and selecting a name from the table.	
8	Funding Source	9 Alpha	Yes	Display Only Table resides in CMS NET #	FUNDING SOURCE Refer to the CMSSAR-60 screen.	
8	EPSDT-SS	1 Alpha	Yes	Display Only	EPSDT-SS This field designates whether the authorization is for an EPSDT-SS. Refer to the CMSSAR-70 screen.	
8	County	14 Alpha	N/A	Display Only	COUNTY Refer to the CMSSAR-60 screen.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
9	Service Classification	15 TBD	N/A	Display Only	SERVICE CLASSIFICATION The classification of the SAR. VALUES TBD	
10	Provider Name	70 Alpha / Numeric	N/A	Display Only	PROVIDER NAME Refer to the CMSSAR-50 screen.	
10	Provider Num	9 Alpha / Numeric	N/A	Display Only	PROVIDER NUMBER Refer to the CMSSAR-50 screen..	
11	Service Begin Date	10 Date	N/A	Display Only	SERVICE BEGIN DATE Refer to the CMSSAR-50 screen.	
11	Service End Date	10 Date	N/A	Display Only	SERVICE END DATE Refer to the CMSSAR-50 screen.	
11	Number of Days	3 Numeric	N/A	Display Only	NUMBER OF DAYS Refer to the CMSSAR-50 screen.	
9	EPSDT-SS	1 Alpha	Yes	Display Only	EPSDT-SS Refer to the CMSSAR-60 screen.	
14	Service Code	11 Alpha / Numeric	Yes	User Input / CMS Net Table	SERVICES Refer to the CMSSAR-50 screen.	
14	Description	Alpha / Numeric	Yes	User Input / CMS Net Table	SERVICE DESCRIPTIONS Refer to the CMSSAR-50 screen.	
14	Units	4 Numeric	Yes	User Input	SERVICE UNITS Refer to the CMSSAR-50 screen.	

14	Quantity	4 Numeric	Yes	User Input	SERVICE QUANTITY Refer to the CMSSAR-50 screen.	
14	Amount	8 Numeric	Conditional	User Input	SERVICE AMOUNT Refer to the CMSSAR-60 screen.	
21	PrimDX	70 Alpha / Numeric	N/A	Display Only	PRIMARY DIAGNOSIS Refer to the CMSSAR-50 screen.	
22	SecDX	70 Alpha / Numeric	N/A	Display Only	SECONARY DIAGNOSIS Refer to CMSSAR-50 screen.	
24	Last Update By	Alpha 30	N/A	Display Only	LAST UPDATE BY Displays the last user's name who modified any data.	
24	Date	10	N/A	Display Only	DATE Displays the date of the last change.	

2.3.11 CMSSBM-10, SAR Branch Menu

The CMSSBM-10 Branch Menu is presented below. The Branch Menu is typically displayed after a user completes a function selected from the main menu. The Branch Menu allows access to specified functions for a previously selected patient, as illustated in the screen header.

Figure 2-11, CMSSBM-10 Branch Menu

```
    12345678901234567890123456789012345678901234567890123456789012345678901234567890
1   CMSNET              SERVICE AUTHORIZATION REQUEST BRANCH MENU             CMSSBM-10
2   Pt Nm: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  CCS#: 9999999  CIN: 99999999X 9
3   Gender: X  DOB: 99/99/9999  Lgl Co: XXXXXXXXXX  REG=XXX  MED=X  F/R=XXXXXXXXXXXX
4   Pgrm Begin Date 99/99/9999 End 99/99/9999 CCS Elig Status XXXXXXXXXXXXXXXXXXXXXX
5
6
7
8   Select Option:
9
10  ()MAIL MESSAGE FOR SAR                    ()AUTHORIZE SAR
11  ()NARRATIVE FOR SAR                       ()CANCEL SAR
12  ()IDENTIFY NEW PATIENT                    ()DENY SAR
13  ()PROCEDURE CODE INQUIRY                  ()ENTER SAR
14  ()FORMULARY FILE INQUIRY                  ()EXTEND SAR
15  ()CATEGORY OF SERVICE INQUIRY             ()MODIFY SAR
16  ()PROVIDER INQUIRY
17  ()PRINT AUTHORIZATIONS
18  ()RETURN TO SAR MAIN MENU
19
20  ()QUIT
21
22
23
24
```

Table 2-4 describes the functions available from the SAR Branch Menu.

Table 2-4, Service Authorization Request Branch Menu Options

Menu Option	Description	Reference
Mail Message for SAR	Displays the existing CMS Net mail message prompt. Messages will be sent through the CMS Net Mail Man function in the existing (legacy) system, since this functionality will not be converted prior to the implementation of the E47 SAR functions.	N/A
Narrative for SAR	Displays the narrative entry/edit screen (CMSEN-10).	N/A
Identify New Patient	Displays the Patient Identification screen (CMSPI-10).	N/A
Procedure Code Inquiry	Displays the procedure code inquiry screen, which enables users to look up a specified procedure code.	Section 3 of this document.
Formulary File Inquiry	Displays Drug Code inquiry screen, which enables users to look up a specified drug code.	Section 3 of this document.
Category of Service Inquiry	Displays the Category of service inquiry screen, which enables users to look up a specified Category of Service code.	Section 3 of this document.

Menu Option	Description	Reference
Provider Inquiry	Displays the provider look up screen. This screen is discussed in greater detail in the Provider specifications.	Section 3 of this document.
Print Authorizations	Displays the print request (PSR-10) screen, which allows users to print medical requests for the selected patient.	Section 3 of this document.
Return to SAR Main Menu	Returns to the Medical Service Main Menu. This menu is discussed in greater detail in section 3.2.6 of this document.	Section 2.3.1 of this document.
Authorize SAR	Allows the user to authorize a SAR for the selected patient.	Figure 2.4 of this document.
Cancel SAR	Allows the user to cancel an authorization for the selected patient.	Figure 2.4 of this document.
Deny SAR	Allows the user to deny a SAR for the selected patient.	Figure 2.4 of this document.
Enter SAR	Allows the user to enter a SAR for the selected patient.	Figure 2.3 of this document.
Extend SAR	Allows the user to extend an authorization for the selected patient.	Figure 2.4 of this document.
Modify SAR	Allows the user to modify an authorization for the selected patient.	Figure 2.4 of this document.

2.3.12 Status Matrix

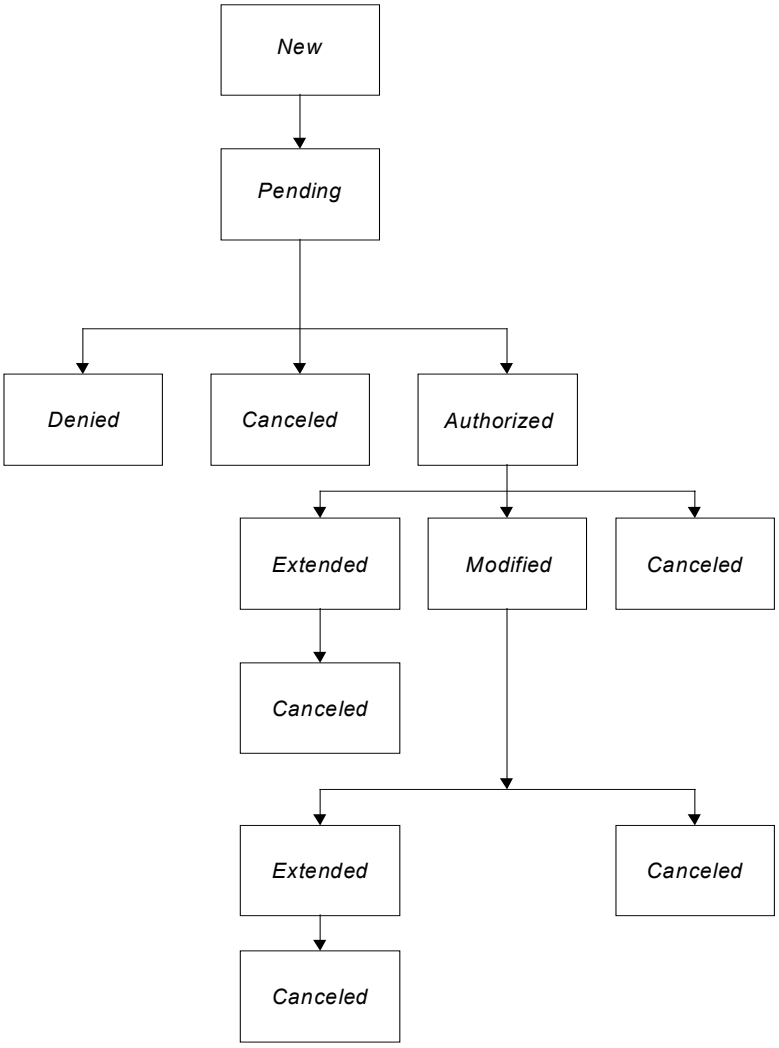
As referenced previously in the screen data dictionaries and business rules, CMS Net will place SAR's in a different status based on the actions that have been taken on them. The matrix below lists each possible status of a SAR, describes the status and presents any relevant business rules, and identifies the screens which impact the SAR status.

Table 2-5, Service Authorization Request Branch Menu Options

Status	Status Definition / Business Rules	Screen
New	• A request that has not been saved to CMS Net. • Includes all requests in that are being entered after a user selects Enter SAR from the Main or Branch Menu. • Users should be able to Save the SAR in CMS Net, which will maintain a record of the SAR in CMS Net and assign it a SAR number. • Users should be able to Save a request without having to complete all required fields on the CMSSAR-50 screen.	**CMSSAR-50**
Pending	• A request that has been entered and Saved into CMS Net. • Pending requests have not yet been authorized or denied. • Requests which do not have all of the required fields on the CMSSAR-50 screen can be saved but will be placed in Pending status. • Users should have the ability to complete all required fields on the CMSSAR-50 screen but still save the SAR and keep it in Pending status. • Only SAR's in New status can be placed in Pending status. • SAR's will be assigned an authorization number by CMS Net when they are placed in Pending Status. • CMS Net should generate an alert to users for any SAR that remains in Pending status beyond a specified period of time. The alert text and time period will be determined.	**CMSSAR-50**
Authorized	• Previously existed in CMS Net in New or Pending status and was authorized using the CMSSAR-60 Authorization of Services screen. • SAR's will maintain the same authorization number when they moved from Pending to Authorized status.	**CMSSAR-60**
Denied	• Previously existed in CMS Net in New or Pending status and was denied using the CMSSAR Denial of Services screen.	**CMSSAR-70**
Extended	• Previously existed in CMS Net in Authorized status and was extended using the CMS extension screen. • Extended SAR's will be assigned a new SAR number New SAR number when its extended. • A SAR can only be extended once (a SAR that is already in extended status cannot be extended again). If an additional extension is required, a new SAR must be opened.	**CMSSAR-85**
Modified	• Previously existed in CMS Net in Authorized status and was modified using the CMS Net CMSSAR-90 screen. • SAR's can only be modified once. A SAR that is already in Modified status cannot be modified again.	**CMSSAR-90**
Canceled	• Previously existed in authorized, extended, or modified status, but was then canceled using the CMSSAR-80 screen.	**CMSSAR-80**

Given the above rules, SAR's must be placed in certain statuses in a specificed sequence. Figure 2-12 presents the flow of the SAR statuses.

Figure 2-12, Status Flow



2.4 ADDITIONAL REQUIREMENTS

This section presents additional requirements related to SAR processing. The following presents a general description of these requirements. The detailed design of system functions related to these requirements has yet been developed.

2.4.1 Processing Rules

Automated edits should be applied to SAR's to ensure that program rules governing the processing of SAR's are adhered to. Most of these rules will apply to the selections of providers and services for a SAR. Examples of such edits may include associations between providers and categories of service or specific procedures which the provider

may render, frequency limitations, age restrictions, etc. Additional analysis prior to development will be required to determine which specific rules shall be applied to the entry and processing of service authorizations. Most of these rules will be based on the data elements included in tables and files downloaded to CMS Net. These tables and files are discussed in greater detail in Section 4 of this document.

2.4.2 Correspondence

CMS Net should automatically generate a printed authorization whenever an authorization is approved, modified, denied, extended or canceled. Multiple copies of the authorization should be produced and addressed so that they can be sent to the patients and providers on an authorization.

A chronological listing of all authorizations should be maintained on-line in CMS Net. User should have the ability to scroll the list of authorizations, select one, and view it on line. Users should also be able to print the authorization as necessary. The print functionality is addressed in this document and included in section 3 of this document.

2.4.3 Narratives

CMS users will require connectivity to the existing full screen case narrative function to add case narratives to a patient's case file. This function is included in the design of the Branch Menu options (see Figure 2-11). The narrative function itself currently exists in CMS Net and is in production.

2.4.4 Ticklers

Ticklers should be developed to remind users of authorization activities which need to be completed by users. A complete list of the CMS Net ticklers has not yet been identified. However, the list should be developed in consultation with CMS Net users and included in the final detailed design of the enhanced system. An example of such a tickler would be a reminder to a CMS Net user to take action on an SAR (e.g. approve or deny it) which has been entered into CMS Net and but which has remained in Pending status beyond a specified period time (such as 30 days).

2.4.5 Security

Security levels must be defined, and available system functions should be associated with these security levels. The association of business functions and security levels must be accomplished in consultation with CMS Net users. An example of the association of business functions and system security levels involve entering and authorizing a SAR. Different security levels should be responsible for entering a SAR into CMS Net and taking action on it (authorizing or denying a SAR; and modifying, extending, or canceling a SAR).

In addition, users with a designated security profile should have the ability to override some of the system edits regarding the entry and authorization of SAR's. For example, CMS program rules prohibit the provision of CMS services to individuals older than 21 years of age. Under some circumstances – and with the approval of a designated case manager or program official - services may be authorized to a child who is under 21

years of age but rendered beyond this date. The ability to approve this exception should be subject to a user's security level.

2.4.6 Help

User Help will be required on all of the authorization screens. Help messages and text for the SAR screens will conform to the overall standards set forth E47 enhancements. These standards will be defined in detail prior to development. It is expected that these requirements will include standard pop up messages (when a cursor is placed on a given field) and / or longer narratives organized by topic or subject.

2.4.7 Reporting

Reports will be generated from the CMS Net database as well as from the fiscal intermediary systems. The fiscal intermediaries will be responsible for reports based on data in the SAF and from other fiscal intermediary systems. Reports from CCS data will be derived from CMS Net. CMS Net reporting requirements are not addressed in this document. Reporting from CMS Net will be addressed a separate document which comprehensively states the CMS reporting requirements on data that resides in CMS Net.

3 SERVICE AUTHORIZATION REQUEST INQUIRIES

3.1 INTRODUCTION

CMS Net users shall have the ability to query the tables that are related to Service Authorization Requests (SAR) and that are stored in CMS Net. The users will also have the ability to print SARs. The functions to query and print are important to processing SARs.

The table below identifies the screens which have been identified and which require development to support the functions above.

Table 3-1, SAR Inquiry Screens

Item	Purpose	Subsection
CMSSARI-10 SAR Inquiry Screen	Used to initiate CMS Net query to the Procedure Code, Dental Procedure Code, Formulary File, and Provider File tables.	3.3.1
CMSPCI-10 Procedure Code Inquiry Summary Screen	Displays multiple results of an inquiry.	3.3.2
CMSPCI-20 Procedure Code Inquiry Detail Screen	Displays the selected procedure code in detail.	3.3.3
CMSPFI-10 Provider File Inquiry Summary Screen	Displays multiple results of an inquiry.	3.3.4
CMSPFI-20 Provider File Inquiry Detail Screen	Displays the selected provider in detail.	3.3.5
CMSFFI-10 Formulary File Inquiry Summary Screen	Displays multiple results of an inquiry.	3.3.6
CMSFFI-20 Formulary File Inquiry Detail Screen	Displays the selected NDC code in detail.	3.3.7
CMSPSR-10 Print SAR Inquiry Screen	Used to initiate CMS Net inquiry of SARs in CMS Net.	3.3.8
CMSPSR-20 Print SAR Summary Screen	Displays multiple results of an inquiry.	3.3.9
CMSDCI-10 Dental Procedure Code Inquiry Summary Screen	Displays multiple results of an inquiry.	3.3.10
CMSDCI-30 Dental Procedure Code Inquiry Detail Screen	Displays the selected NDC code in detail.	3.3.11

3.2 SERVICE AUTHORIZATION REQUERT INQUIRY SCREENS FLOW

Users can access the CMS Net Service Authorization Request (SAR) Inquiry screens and SAR print screens by making an appropriate selection from the CMSSMM-10 Main Menu or the CMSSBM-10 Branch Menu. Screen and process flows for functions originating from Main Menu and Branch Menu are presented below.

3.2.1 Processes and Screen Flow

The following flow chart illustrates the flow of the SAR Inquiry processing screens. Figure 3.1 depicts the screens and process for querying the SAR tables in CMS Net. The Procedure Code, Dental Procedure Code, Formulary File, and Provider inquiry screens and processes follow the same path but take the users to their screens respectively.

Figure 3.2 and depicts the screens and process for printing SAR's from the main menu when a patient has not been selected. The process is the same when a client has been selected except that only SAR's for that client will be returned.

Figure 3.1, SAR Query Screen Flow

SAR Inquiries from the Main Menu

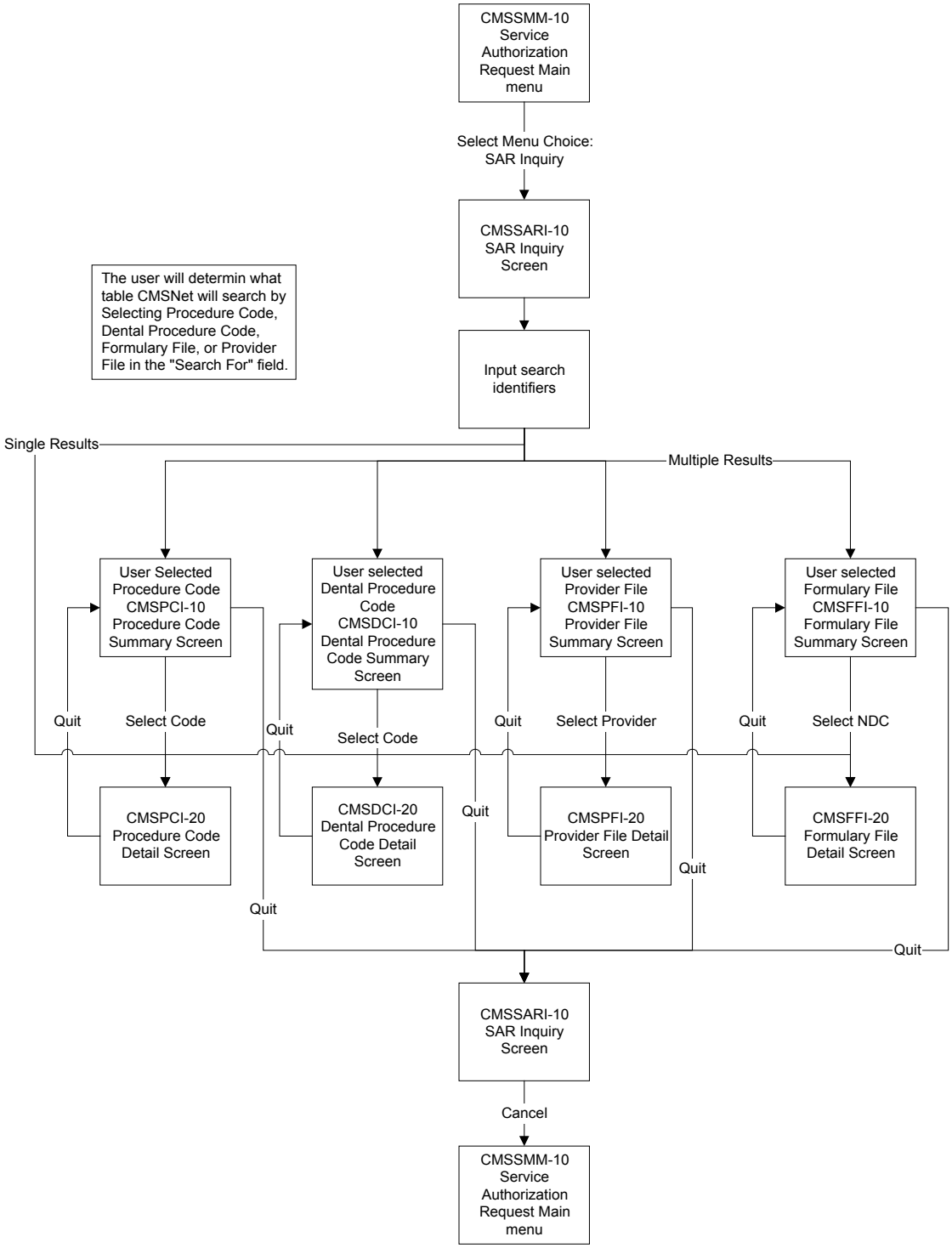
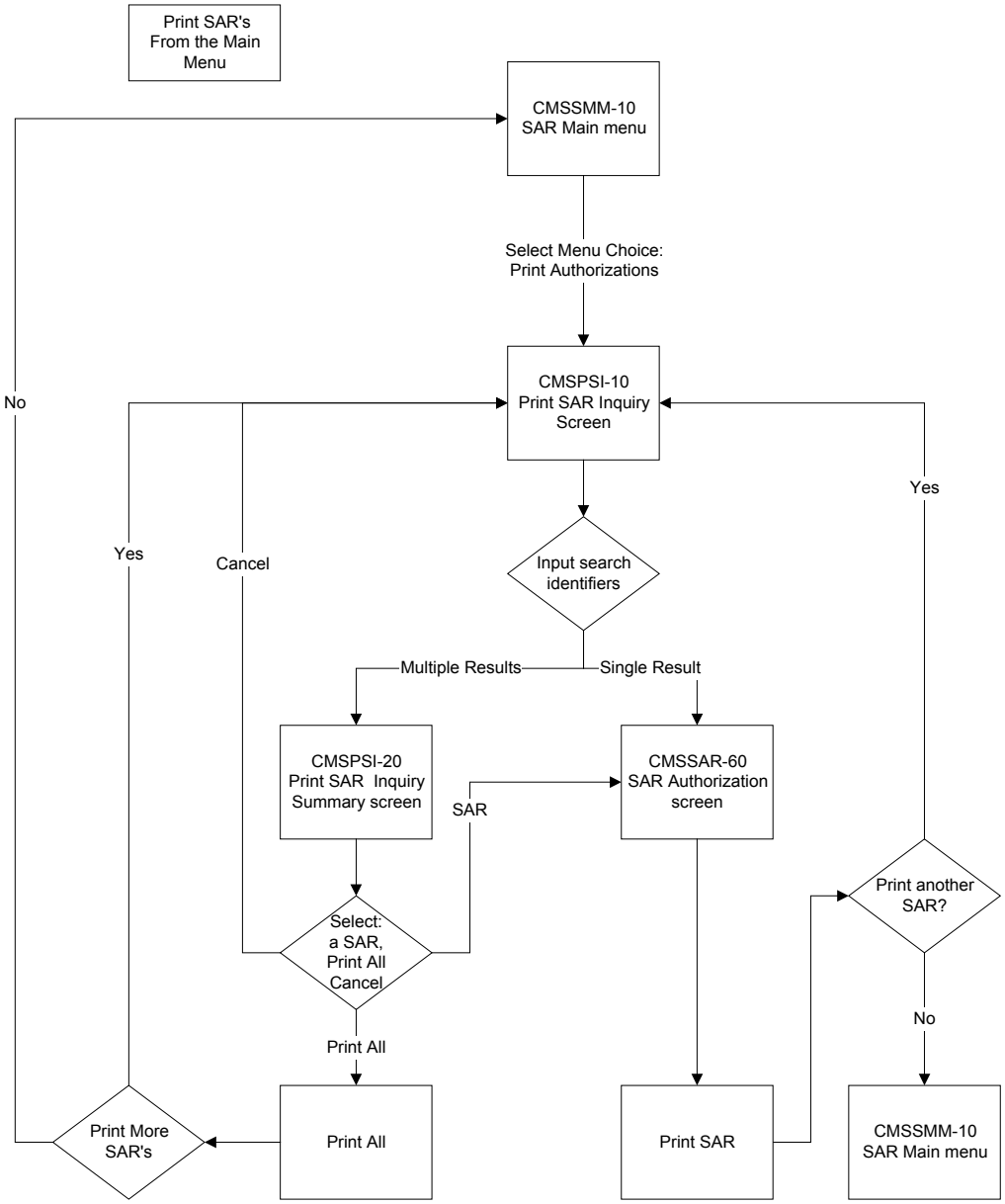


Figure 3.2, SAR Print Screen Flow

Print SAR from the Main Menu



3.3 SAR INQUIRY SCREENS AND DATA DICTIONARIES

The subsections that follow present the basic screens used for inquiring the Procedure Code, Dental Procedure Code, Provider File, and Formulary File. Each subsection presents a brief description of the screen, business rules which apply to the screen, and illustration of the screen, and a screen data dictionary. The screens are currently presented in a text-based format in order to present the data which will be required for each screen. However, it is expected that these screens will be implemented with a graphical user interface (GUI).

3.3.1 CMSSARI-10, SAR Inquiry

The CMSSARI-10 screen is used to initiate a query of the Procedure Code, Provider File Code, Formulary File, or Dental Procedure tables in CMS Net. The screen includes the parameters that can be entered into CMS Net.

3.3.1.1Screen Reference Layout

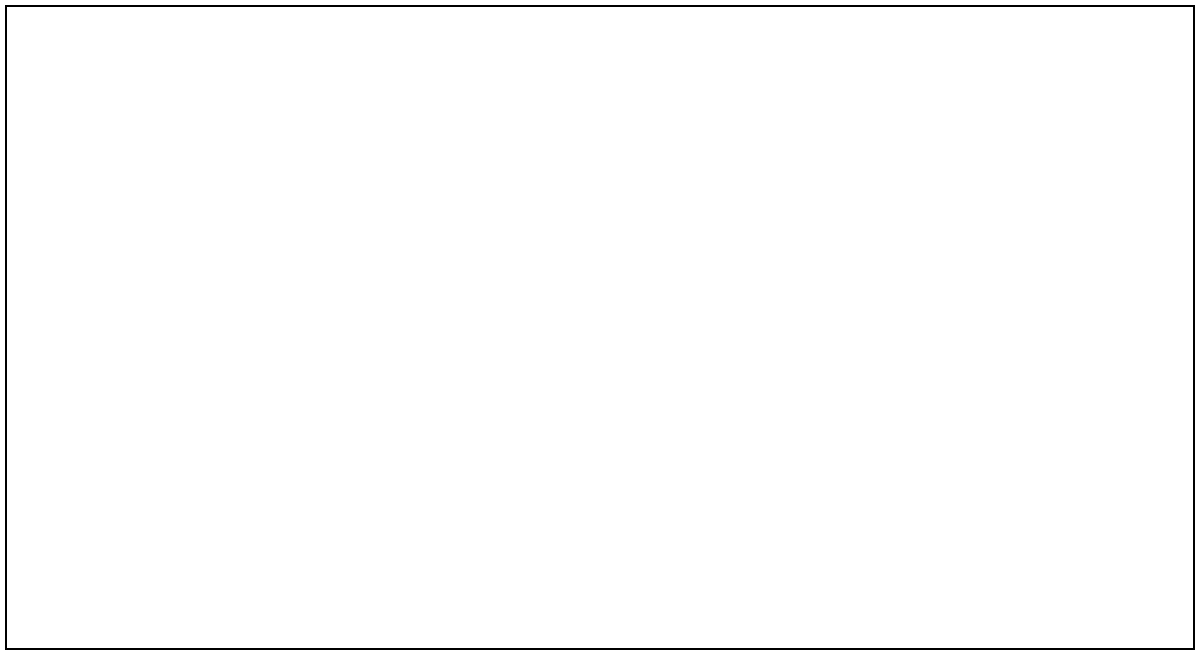
Refer to figure 3.1, CMSSARI-10 Screen layout, for a pictorial representation of the screen.

Figure 3.1, CMSSARI-10 Screen

```
        0         1         2         3         4         5         6         7         8
        12345678901234567890123456789012345678901234567890123456789012345678901234567890
1       CMSNET                                SAR INQUIRY                          CMSSARI-10
2
3       Enter one or more of the Identifiers:

4       Search for:XXXXXXXXXXXXXXXX

5       Type: X Procedure Code: X9999 Name:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
6
        Provider Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
7       Provider Number: X99999999
        Address: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
8          City: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        ZIP Code:99999
9
        NDC Code:99999999999
        Brand Drug Name:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
10      Generic Drug Name:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
11
        Dental Procedure Code:99999
12
13
14
15
16
17
18
19
```



3.3.1.2Screen Business Rules

The following business rules apply to the CMSSARI-10 Screen:

- This screen will be used to query the Procedure Code, Dental Procedure Code, Formulary File, and Provider File CMS Net tables.
- The “Search For” field and at least one of the other fields must be completed to invoke the search.

3.3.1.3 Data Dictionary

Table 3.2 details each of the data fields that should be included on the CMSSARI-10 screen, along with their attributes.

Table 3.2, CMSSARI-10 Data Dictionary

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
	Search for		Yes	User input/CMS Net Table	SEARCH FOR This field will determine what CMS Net table to search on. Values: Procedure Code Dental Procedure Code Formulary File Provider File	
7	Type	1 Alpha	Conditional	User input/CMS Net Table	PROCEDURE CODE TYPE This field classifies procedures into distinct procedure groups. The user must have selected Procedure Code in the Search For field to enter search parameters in the Procedure Type field. If user inputs only a Procedure code type, then CMS Net will return on CMSPCI-20 all the Procedure codes that have that value. If user inputs Procedure type and one or more other data elements, then CMS Net will return No matches or display on CMSPCI-20 the valid matches.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
7	Procedure Code	5 Alpha-/Numeric	Conditional	User input/CMS Net Table	PROCEDURE CODE The Medical Procedure codes. The user must have selected Procedure Code in the Search For field to enter search parameters in the Procedure code field. A full or partial code can be entered to invoke a search of the Procedure Code File for the desired code. If the user enters a partial code than CMS Net will return No results or the results of the matched partial code entered on the CMSPCI-20 screen and the user will be able to select a procedure code from a list of codes returned. If a user enters a complete and valid procedure code, the system shall return the results of the code on the CMSPCI-20 screen and the user will be able to select a procedure code from a list of codes returned or return to the CMSPCI-10 Screen. If a user enters a procedure type, a complete and valid procedure code, the system shall populate all fields on CMSPCI-30 screen with the information.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
7	Name	40 Alpha	Conditional	User input/CMS Net Table	PROCEDURE CODE NAME Description of the Procedure Code. The user must have selected Procedure Code in the Search For field to enter search parameters in the Procedure name field. Users may enter full or partial name in order to invoke a search of the Procedure Code File for the desired code. If the user enters a partial name, and No results are returned the user will stay in the CMSSARI-10 Screen. If CMS Net finds matches, then CMSPCI-10 screen will display the results and the user will be able to select a procedure code from the codes returned and go to the CMSPCI-20 Screen or go back to the CMSSARI-10 Screen. If a user enters a complete and valid procedure code name, the system shall return the results of the code on the CMSPCI-10 screen and the user will be able to select a procedure code from the codes returned and go to the CMSPCI-20 Screen or return to the CMSSARI-10 Screen. If a user enters a procedure type, a complete and valid procedure code name, the system shall populate all fields on CMSPCI-20 screen with the information.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
9	NDC Code	11	Conditional	User input/CMS Net Table	NDC CODE The 11 digit NDC code. If the user selected Formulary File than the user will only be able to enter search parameters in the NDC Code field. A full or partial code can be entered to invoke a search of the Formulary File for the desired code. If the user enters a partial NDC, and No results are returned the user will stay in the CMSSARI-10 Screen. If the user enters a partial code and CMS Net finds matches it will return results of the matched partial NDC on the CMSFFI-10 screen and the user will be able to select an NDC from the list and go to CMSFFI-20 or return to the CMSSARI-10 Screen. If a user enters a complete and valid NDC the system shall populate all fields on CMSFFI-20 screen.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
10	Brand Drug Name	40	Conditional	User input/CMS Net **Table**	BRAND DRUG NAME The brand name of the drug. If the user selected Formulary File than the user will only be able to enter search parameters in the Brand name field. A full or partial name can be entered to invoke a search of the Formulary File for the desired code. If the user enters a partial name, and No results are returned the user will stay in the CMSSARI-10 Screen. If the user enters a partial name and CMS Net finds matches it will return results of the matched partial name on the CMSFFI-10 screen and the user will be able to select an NDC from a list returned or return to the CMSSARI-10 Screen. If a user enters a complete and valid name, the system shall populate all fields on CMSFFI-20 screen.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
11	Generic Drug Name	40	Conditional	User input/CMS Net Table	GENERIC DRUG NAME The generic name of the drug. If the user selected Formulary File than the user will only be able to enter search parameters in the Generic name field. A full or partial name can be entered to invoke a search of the Formulary File for the desired code. If the user enters a partial name, and No results are returned the user will stay in the CMSSARI-10 Screen. If the user enters a partial name and CMS Net finds matches it will return results of the matched partial name on the CMSFFI-10 screen and the user will be able to select an NDC from a list returned or return to the CMSSARI-10 Screen. If a user enters a complete and valid name, the system shall populate all fields on CMSFFI-20 screen.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
13	Provider Name	40	Conditional	User input/CMS Net Table	PROVIDER NAME Name of the provider. If the user selected Provider File than the user will only be able to enter search parameters in the Provider Name field. A full or partial name can be entered to invoke a search of the Provider File for the desired Provider. If the user enters a partial name, and No results are returned the user will stay in the CMSSARI-10 Screen. If the user enters a partial name and CMS Net finds matches it will return results of the matched partial name on the CMSSPFI-10 screen and the user will be able to select a provider from a list returned or return to the CMSSARI-10 Screen. If a user enters a complete and valid name the system shall populate all fields on CMSPFI-20 screen.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
14	Provider Number	9	Conditional	User input/CMS Net **Table**	PROVIDER NUMBER The provider's Medi-Cal provider number. If the user selected Provider File than the user will only be able to enter search parameters in the Provider number field. A full or partial number can be entered to invoke a search of the Provider File for the desired Provider. If the user enters a partial number, and No results are returned the user will stay in the CMSSARI-10 Screen. If the user enters a partial number and CMS Net finds matches it will return results of the matched partial number on the CMSSPFI-10 screen and the user will be able to select a provider from a list and go to CMSPFI-20 or return to the CMSSARI-10 Screen. If a user enters a complete and valid number the system shall populate all fields on CMSPFI-20 screen.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
15	Address		Conditional	User input/CMS Net Table	PROVIDER SERVICE ADDRESS The providers' street address. If the user selected Provider File than the user will only be able to enter search parameters in the Provider address field. A full or partial address can be entered to invoke a search of the Provider File for the desired Provider. If the user enters a partial address, and No results are returned the user will stay in the CMSSARI-10 Screen. If the user enters a partial address and CMS Net finds matches it will return results of the matched partial address on the CMSSPFI-10 screen and the user will be able to select a provider from a list and go to CMSPFI-20 or return to the CMSSARI-10 Screen. If a user enters a complete and valid address the system shall populate all fields on CMSPFI-20 screen.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
16	City		Conditional	User input/CMS Net Table	PROVIDERS CITY The provider's city. If the user selected Provider File than the user will only be able to enter search parameters in the Provider city field. A full or partial city can be entered to invoke a search of the Provider File for the desired Provider. If the user enters a partial city, and No results are returned the user will stay in the CMSSARI-10 Screen. If the user enters a partial city and CMS Net finds matches it will return results of the matched partial city on the CMSSPFI-10 screen and the user will be able to select a provider from a list and go to CMSPFI-20 or return to the CMSSARI-10 Screen.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
17	Zip		Conditional	User input/CMS Net Table	PROVIDER ZIP CODE The providers zip code. If the user selected Provider File than the user will only be able to enter search parameters in the Provider zip field. Users may enter full or partial Zip code in order to invoke a search of the Provider File for the desired code. If the user enters a partial zip code, and No results are returned the user will stay in the CMSSARI-10 Screen. If the user enters a partial zip code and CMS Net finds matches it will return results of the matched partial zip code on the CMSSPFI-10 screen and the user will be able to select a provider from a list and go to CMSPFI-20 or return to the CMSSARI-10 Screen.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
19	Dental Procedure Code	5 Numeric	Conditional	User input/CMS Net Table	DENTAL PROCEDURE CODE The dental procedure code. If the user selected Dental Procedure Code than the user will only be able to enter search parameters in the Dental Procedure Code field. Users may enter full or partial code in order to invoke a search of the Dental Procedure Code table for the desired code. If the user enters a partial code, and No results are returned the user will stay in the CMSSARI-10 Screen. If CMS Net finds matches, then CMSDCI-10 screen will display the results and the user will be able to select a procedure code from the codes returned and go to the CMSDCI-20 Screen or go back to the CMSSARI-10 Screen. If a user enters a complete and valid procedure code, the system shall return the results of the code on the CMSDDCI-20 screen.	

3.3.2 CMSPCI-10, Procedure Code Inquiry Summary Screen

The CMSPCI-10 screen displays the results of the query of the procedure code table the user initiated. The user will be able to select a code and see the details of that code.

3.3.2.1 Screen Reference Layout

Refer to figure 3.2, CMSPCI-10 Screen layout, for a pictorial representation of the screen.

Figure 3.2, CMSPCI-10 Screen

```
0        1         2         3         4         5         6         7         8
12345678901234567890123456789012345678901234567890123456789012345678901234567890

CMSNET              PROCEDURE CODE INQUIRY SUMMARY                    CMSPCI-10
Procedure
Type  Code: Name:
X     X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
X     X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
X     X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
X     X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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X     X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
X     X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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3.3.2.2 Screen Business Rules

The following business rules apply to this screen:

- All records that fit the query parameters entered on the CMSSARI-10 screen will be displayed on this screen if the user selected Procedure Code in the 'Search For' field.
- The user will be able to select a code or return to the previous screen.
- Users should be able to scroll the list of codes, select a code, and take the user to the CMSPCI-20 screen.

3.3.2.3 Data Dictionary

Table 3.3 details each of the data fields that should be included on the CMSPCI-10 screen, along with their attributes.

Table 3.3, CMSPCI-10 Data Dictionary

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
3	Type	1 Alpha	Display	CMS Net Table	PROCEDURE CODE TYPE This field classifies procedures into distinct procedure groups.	
3	Procedure Code	5 Alpha/Numeric	Display	CMS Net Tables	PROCEDURE CODE The Medical Procedure code.	
3	Name	40 Alpha	Display	CMS Net Table	PROCEDURE CODE NAME Description of the Procedure Code.	

3.3.3 CMSPCI-20, Procedure Code Inquiry Detail Screen

The CMSPCI-20 screen displays the detail of the procedure code the user selected from the summary screen or the result of inputting both a type and code on the CMSSARI-10 screen.

3.3.3.1Screen Reference Layout

Refer to figure 3.3, CMSPCI-20 Screen layout, for a pictorial representation of the screen.

Figure 3.3, CMSPCI-20 Screen

```
        0         1         2         3         4         5         6         7         8
        12345678901234567890123456789012345678901234567890123456789012345678901234567890

1       CMSNET                PROCEDURE CODE INQUIRY DETAIL                   CMSPCI-20
2
3       Type X Procedure Code: X9999 Name:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

4       Status Begin Date: 99/99/9999 End Date: 99/99/9999
         MAX:X UVSP:99 Sex:X Min Age:99 Max Age:99 EPSDT:X
5
6        DATE:      P/D E/P TAR I/E Places of Service
        99/99/9999 X    X     X    X XX XX XX XX XX XX XX XX XX XX
7       99/99/9999 X    X     X    X XX XX XX XX XX XX XX XX XX XX
        99/99/9999 X    X     X    X XX XX XX XX XX XX XX XX XX XX
8       99/99/9999 X    X     X    X XX XX XX XX XX XX XX XX XX XX
        99/99/9999 X    X     X    X XX XX XX XX XX XX XX XX XX XX
9       99/99/9999 X    X     X    X XX XX XX XX XX XX XX XX XX XX

        Conv Ind From   Date Thru         Units     Price
10      XX       99/99/9999  99/99/9999  9999999   9999999
11      XX       99/99/9999  99/99/9999  9999999   9999999
        XX       99/99/9999  99/99/9999  9999999   9999999
12      XX       99/99/9999  99/99/9999  9999999   9999999
        XX       99/99/9999  99/99/9999  9999999   9999999
13      XX       99/99/9999  99/99/9999  9999999   9999999

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3.3.3.2Screen Business Rules

The following business rules apply to this screen:

- This screen will display the detail inquiry results of a selected procedure code from the CMS Net Procedure Code table.
- This screen will be display only.

3.3.3.3 Data Dictionary

Table 3.4 details each of the data fields that should be included on the CMSPCI-20 screen, along with their attributes.

Table 3.4, CMSPCI-20 Data Dictionary

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
3	Type	1 Alpha	Display Only	CMS Net Tables	PROCEDURE CODE TYPE This field classifies procedures into distinct procedure groups. Values: A- LA County I- Injections J- Anesthesia K- Surgery L- Radiology M- Pathology N- Medicine O- Assistant Surgeon P- Podiatrist 1-HCPCS/SMA 0-Other	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
3	Procedure Code	5 Alpha/Numeric	Display Only	CMS Net Tables	PROCEDURE CODE The Medical Procedure codes are from the Medi-Cal procedure code master file.. Values: CPT –4 equivalent to HCPCS LEVEL 1. The ranges 00100-01999, and 10000-99999. CSN procedure range is 10000-99999 and became obsolete 10/31/87. SMA procedure cods are four-digit numeric codes that became obsolete 10/01/92. HCPCS Level II and III codes replace SMA and Medi-Cal only codes and are four-digit numeric prefixed by an alpha character. Level II HCPCS are A0001-V9999, Level III HCPCS are W0001-Z9999. Medi-Cal code are X and Z prefixes only. Contractor defined codes used for injection and miscellaneous items.	
3	Name	40 Alpha	Display Only	CMS Net Tables	PROCEDURE CODE NAME Description of the Procedure Code. The name reflects the description in the CPT/HCPCS/Title 22.	
5	Effective Begin Date	10 Date	Display Only	CMS Net Tables	PROCEDURE EFFECTIVE DATE Date on which the procedure become an active code on the Medi-Cal Program.	
5	Ending Date	10 Date	Display Only	CMS Net Tables	PROCEDURE ENDING DATE Date on which the procedure ceases to be an active code on the Medi-Cal Program.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
6	Max	1 Alpha/Numeric	Conditional	CMS Net Table	MAX PERIOD The period of time for maximum units Values: D,0,9=Daily W=Weekly M=Monthly S=Single Service (can not be blocked billed) G=Global Service (must be block billed)	
6	UVSP	2 Numeric	Display Only	CMS Net Tables	MAXIMUM UNITS The maximum number of units, visits or studies per UVS period that may be reimbursed under the particular procedure. The default is 99. If the claim is from/thru billed, the system will allow the maximum value times the number of days billed. The MAX Period and Maximum units are used in conjunction with the Pend/Deny indicator. If the Pend/Deny indicator is 0, and original claim will be cutback by the system if billing over the maximum unit amount for the MAX Period. If the Pend/Deny indicator is a "U," original claims billing over the Maximum amount will suspend for error code 409. Values: 0-99	
6	Sex	1 Alpha	Display Only	CMS Net Tables	SEX CODE Sex requirement for procedure.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
6	Min Age	2 Numeric	Display Only	CMS Net Tables	MINIMUM AGE Minimum age requirement for procedure.	
6	Max Age	2 Numeric	Display Only	CMS Net Tables	MAXIMUM AGE Maximum age requirement for procedure.	
6	EPSDT	1 Alpha	Display Only	CMS Net Tabel	EPSDT-SS EPSDT-SS indicator.	
8	Date	10 Date	Display Only	CMS Net Tables	INDICATOR SPECIFIC DATE The Date of Service for the following indicators: Pend/Deny, ER/POS, TAR, POS.	
8	P/D	1 Alpha	Display Only	CMS Net Table	PEND/DENY INDICATOR Procedures that should suspend for manual review or denied as non-covered benefits are flagged with this indicator. The indicator is DOS specific. Values: P=suspend for medical necessity D=not a covered benefit T=obsolete code M=suspend for sterilization review R=crossover correlation procedure only U=suspend f billed quantity exceeds UVSP on file 0=no suspension/denial is applicable	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
8	E/P	1 Alpha	Display Only	CMS Net Tables	EMERGENCY INDICATOR Directs the system to the proper conversion indicator to use if the POS is ER. Values: 1=If place of service is B or 23(ER) use ER medicine or surgical conversion factor 0=Use non-emergency conversion factor no matter what place of service	
8	TAR	1 Numeric	Display Only	CMS Net Tables	TREATMENT AUTHORIZATION REQUEST(TAR) Indicates procedures requiring a TAR, or MEDI reservation. Values: 0=No TAR or Medi service Reservation required 1=Medi Service Reservation or TAR Required 2=Medi Service Reservation only required NO TAR override 3=TAR only required 4=Refer to MMIS Table 1355 for TAR/Medi requirement	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
8	I/E	1 Alpha	Display Only	CMS Net Tables	POS I/E INDICATOR This indicator shows valid or invalid POS for the code. Values: I=Inclusive – code is only payable when billed with the POS code. E=Exclusive – code is only payable when not billed with the POS code.	
8	Places of Service		Display Only	CMS Net Tables	POS CODE The alpha/numeric code that either must be present or cannot be present.	
16	Conv Ind	2 Numeric	Display Only	CMS Net Tables	CONVERSION INDICATOR Directs the system to the proper method for calculating the payable amount for the procedure.	
16	From Date	10 Date	Display Only	CMS Net Tables	UNIT FROM DATE Date the procedure unit value is effective. The system can store up to 7 occurrences for Unit From Date.	
16	Thru	10 Date	Display Only	CMS Net Tables	UNIT THRU DATE Date the procedure unit value ceases to be effective. The system can store up to 7 occurrences for Unit Thru Date.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
16	Units	7 Numeric	Display Only	CMS Net Tables	BASIC UNIT VALUE Contains the unit value of fixed-price amount corresponding to the conversion indicator displayed, which determines the payable amount for the procedure.	
16	Price	7 Numeric	Display Only	CMS Net Tables	PRICE This field defines the Medi-Cal allowed amount for the procedure. It is determined by multiplying the dollar conversion defined in the conversion indicator field times the basic unit value.	

3.3.4 CMSPFI-10, Provider File Inquiry Summary

The CMSPFI-10 screen displays the results of the inquiry of the Provider File table the user initiated. The user will be able to select a provider and see the details of that provider.

3.3.4.1Screen Reference Layout

Refer to figure 3.4, CMSPFI-10 Screen layout, for a pictorial representation of the screen.

Figure 3.4, CMSPFI-10, Screen

```
          0         1         2         3         4         5         6         7         8
          12345678901234567890123456789012345678901234567890123456789012345678901234567890

 1        CMSNET                PROVIDER FILE INQUIRY SUMMARY                    CMSPFI-10
 2
 3        Select one or rtrn
          Provider  Provider
 4        Number    Name                                          City
          X99999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXX
 5        X99999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXX
 6        X99999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXX
          X99999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXX
 7        X99999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXX
          X99999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXX
 8        X99999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXX
          X99999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXX
 9        X99999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXX
          X99999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXX
          X99999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXX
10        X99999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXX
11        X99999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXX
          X99999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXX
12        X99999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXX
          X99999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXX
13        X99999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXX
          X99999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXX
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3.3.4.2Screen Business Rules

The following business rules apply to this screen:

- All records that fit the query parameters entered on the CMSSARI-10 screen will be displayed on this screen if the user selected Provider File in the Search For field.
- All information on the screen will be display only.
- Users should be able to scroll the list of providers, select a provider, and take the user to the CMSPFI-20 screen or return to the previous screen.

3.3.4.3 Data Dictionary

Table 3.5 details each of the data fields that should be included on the CMSPFI-10 screen, along with their attributes

Table 3.5, CMSPFI-10 Data Dictionary

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
5	Provider Name	9 Alpha	Display Only	CMS Net PMF	PROVIDER NAME Name of the provider.	
5	Provider Number	40 Alpha/Numeric	Display Only	CMS Net PMF	PROVIDER NUMBER The provider's Medi-Cal provider number.	
5	City	20 Alpha	Display Only	CMS Net PMF	PROVIDERS CITY The provider's city.	

3.3.5 CMSPFI-20, Provider File Inquiry Detail

The CMSPFI-20 screen displays the detail of the provider the user selected from the summary screen or the results of inputting a complete provider number or name on the CMSPFI-10 screen.

3.3.5.1Screen Reference Layout

Refer to figure 3.5, CMSPFI-20 Screen layout, for a pictorial representation of the screen.

Figure 3.5, CMSPFI-20 Screen

```
          0        1         2         3         4         5         6         7         8
          12345678901234567890123456789012345678901234567890123456789012345678901234567890
1         CMSNET                  PROVIDER FILE INQUIRY DETAIL                  CMSPFI-20
2
3         Provider    Provider
          Number      Name
4         X99999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

5         StatusCode Date        COS  Begin date End Date
6              9     99/99/9999   999 99/99/9999 99/99/9999
               9     99/99/9999   999 99/99/9999 99/99/9999
7              9     99/99/9999   999 99/99/9999 99/99/9999
               9     99/99/9999   999 99/99/9999 99/99/9999
8              9     99/99/9999   999 99/99/9999 99/99/9999
          Service
9         Address: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             City: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            State: XX  Zip: 999999
10        Telephone No: 999-999-9999
11
          Panel: X
12        SCC Assc: X

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```

3.3.5.2Screen Business Rules

The following business rules apply to this screen:

- This screen will display the detail results of a selected provider from the CMS Net Provider table.
- All information on the screen will be display only.

3.3.5.3 Data Dictionary

Table 3.6 details each of the data fields that should be included on the CMSPFI-20 screen, along with their attributes.

Table 3.6, CMSPFI-20 Data Dictionary

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
4	Provider Name	40 Alpha	Display Only	CMS Net PMF	PROVIDER NAME Name of the provider.	
4	Provider Number	9 Alpha/Numeric	Display Only	CMS Net PMF	PROVIDER NUMBER The provider's Medi-Cal provider number.	
7	Status Code	1 Numeric	Display Only	CMS Net PMF	PROVIDER STATUS The providers Medi-Cal status.	
7	Date	10 Date	Display Only	CMS Net PMF	PROVIDER STATUS DATE The date the provider's Medi-Cal status became effective.	
7	COS	3 Numeric	Display Only	CMS Net PMF	CATEGORY OF SERVICE CODE (COS) The providers category of service.	
	Begin Date	10 Date	Display Only	CMS Net PMF	COS EFFECTIVE DATE The date the providers COS became effective.	
7	End Date	10 Date	Display Only	CMS Net PMF	COS END DATE The date the providers COS ceases.	
14	Service Address	40 Alpha/Numeric	Display Only	CMS Net PMF	SERVICE ADDRESS The providers' street address.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
15	City	40 Alpha	Display Only	CMS Net PMF	SERVICE CITY The providers' city.	
16	State	20 Alpha	Display Only	CMS Net PMF	SERVICE STATE The providers' state.	
16	ZIP	5 Numeric	Display Only	CMS Net PMF	SERVICE ZIP The providers zip code.	
17	Telephone Number	12 Numeric	Display Only	CMS Net PMF	SERVICE TELEPHONE NUMBER The providers service telephone number.	
19	Panel	1 Alpha	Display Only	CMS Net PMF	PROVIDER PANEL INDICATOR Providers panel indicator.	
20	SCC Ascc	1 alpha	Display Only	CMS Net PMF	PROVIDER SPECIAL CARE CENTER ASSOCIATION Providers SCC indicator.	

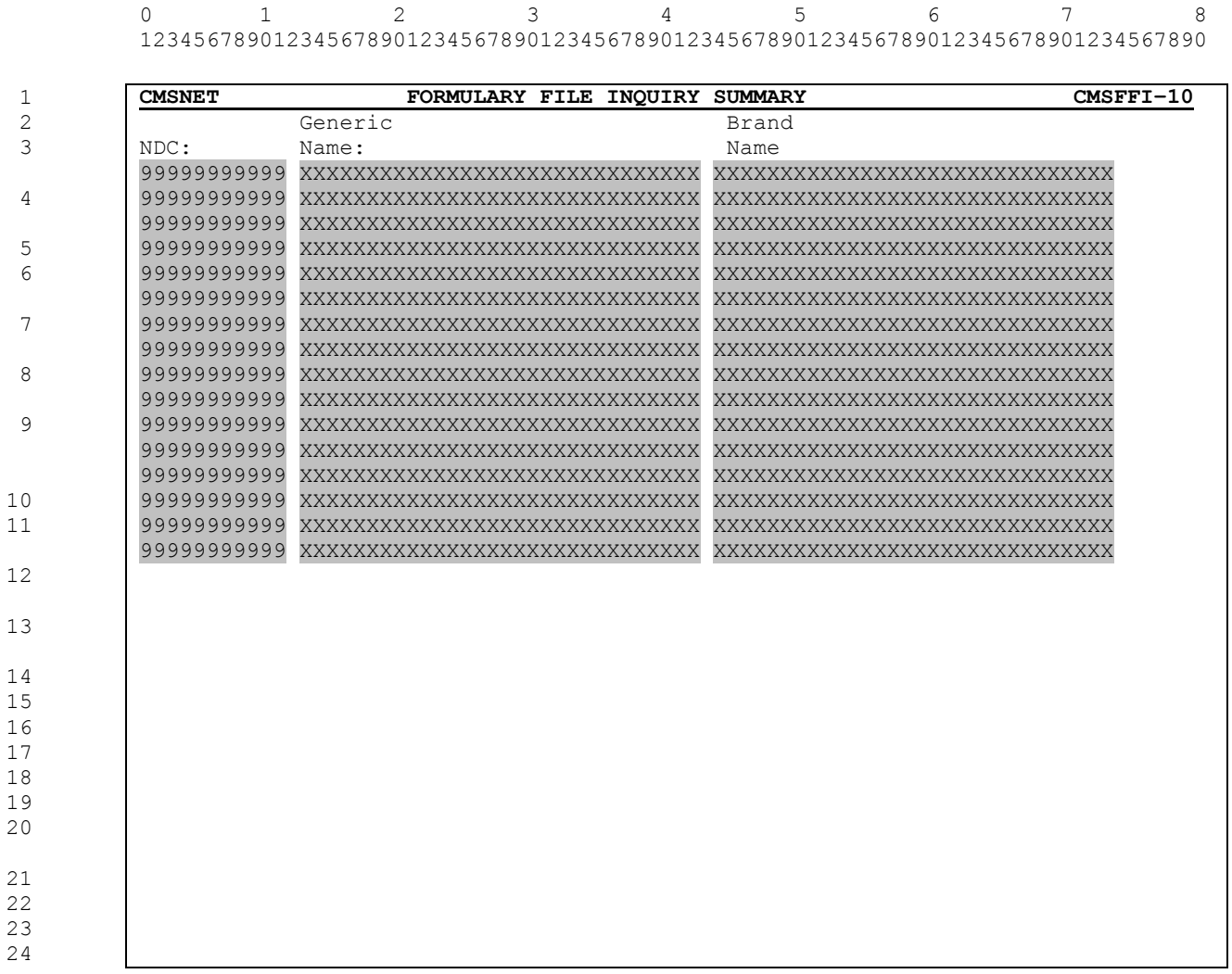
3.3.6 CMSFFI-10, Formulary File Inquiry Summary

The CMSFFI-10 screen displays the results of an inquiry of the CMS Net formulary file table.

3.3.6.1 Screen Reference Layout

Refer to Figure 3.6, CMSFFI-10 Screen layout, for a pictorial representation of the screen.

Figure 3.8, CMSFFI-10 Screen



3.3.6.2Screen Business Rules

The following business rules apply to this screen:

- This screen will display the results of a search of the CMS Net Formulary File table.
- The screen will be display the records that fit the query parameters entered on the CMSSARI-10 screen will be displayed on this screen if the user selected Formulary File in the ‘Search For’ field.
- Users should be able to scroll the list of NDC’S, select an NDC, and take the user to the CMSFFI-20 screen or return to the previous screen.

3.3.6.3 Data Dictionary

Table 3.7 details each of the data fields that should be included on the CMSFFI-10 screen, along with their attributes.

Table 3.7, CMSFFI-10 Data Dictionary

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
3	NDC	11 Numeric	Display Only	CMS Net Formulary File	NATIONAL DRUG CODE The 11 digit NDC on the file.	
3	Drug Brand Name	40 Alpha/Numeric	Display Only	CMS Net Formulary File	DRUG BRAND NAME The label name of the drug.	
3	Drug Generic Name	40 Alpha/Numeric	Display Only	CMS Net Formulary File	DRUG GENERIC NAME The generic name of the drug.	

3.3.7 CMSFFI-20, Formulary File Inquiry Detail

The CMSFFI-20 screen displays the detail results of a selected NDC in the CMS Net Formulary File table.

3.3.7.1 Screen Reference Layout

Refer to Figure 3.7, CMSFFI-20 Screen layout, for a pictorial representation of the screen.

Figure 3.7, CMSFFI-20 Screen

```
      0        1         2         3         4         5         6         7         8
      12345678901234567890123456789012345678901234567890123456789012345678901234567890
1     CMSNET                        FORMULARY FILE INQUIRY DETAIL                CMSFFI-20
2
3     NDC:99999999999
      Drug Brand Name:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
4     Drug Generic Name:XXXXXXXXXXXXXXXXXXXXXXXXXXXXX

5     Begin Date: 99/99/9999 End Date99/99/9999
6     Prev BGN Date:99/99/9999 Prev End Date:99/99/9999

7     TAR:X Sex:X Code 1:X Disp Fee:X LGN Ind:
      Min Age:XX Max Age:XX Min Qty:99999 Max Qty:99999
8
      Effective Date FAC      AWP       MAIC     EAC      Lowest Cost
9     99/99/9999     999.9999 999.9999 999.9999 999.9999 999.9999
      99/99/9999     999.9999 999.9999 999.9999 999.9999 999.9999
      99/99/9999     999.9999 999.9999 999.9999 999.9999 999.9999
10    99/99/9999     999.9999 999.9999 999.9999 999.9999 999.9999
11    99/99/9999     999.9999 999.9999 999.9999 999.9999 999.9999

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3.3.7.2Screen Business Rules

The following business rules apply to this screen:

- This screen will display the detail results of a selected NDC code from the CMS Net Formulary File table.
- The screen will be display only.

3.3.7.3 Data Dictionary

Table 3.8 details each of the data fields that should be included on the CMSFFI-20 screen, along with their attributes.

Table 3.8, CMSFFI-20 Data Dictionary

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
3	NDC	11 Alpha	Display Only	CMS Net Formulary File	NATIONAL DRUG CODE The 11 digit NDC on the file.	
4	Brand Name	40 Alpha/Numeric	Display Only	CMS Net Formulary File	DRUG BRAND NAME The label name of the drug.	
5	Generic Name	40 Alpha/Numeric	Display Only	CMS Net Formulary File	DRUG GENERIC NAME The generic name of the drug.	
7	Begin Date	10 Date	Display Only	CMS Net Formulary File	NDC BEGIN DATE The NDC begin date.	
7	End Date	10 Date	Display Only	CMS Net Formulary File	NDC END DATE The NDC end date.	
8	Prev Begin Date	10 Date	Display Only	CMS Net Formulary File	NDC PREVIOUS BEGIN DATE The NDCs previous begin date.	
8	Prev End Date	10 Date	Display Only	CMS Net Formulary File	NDC PREVIOUS END DATE The NDCs previous end date.	
10	TAR	1 Numeric	Display Only	CMS Net Formulary File	TAR INDICATOR Indicates NDCS requiring a TAR	
10	Sex	1 Alpha	Display Only	CMS Net Formulary File	SEX INDICATOR Sex requirement for the NDC.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
10	Code 1	1 Numeric	Display Only	CMS Net Formulary File	CODE 1 INDICATOR Code 1 requirements for the NDC.	
10	Disp Fee	1 Alpha	Display Only	CMS Net Formulary File	DISP FEE INDICATOR Dispensing fee requirements for the NDC.	
10	LGN Ind	1 Alpha	Display Only	CMS Net Formulary File	LGN IND INDICATOR The NDCs legend indicator.	
11	Min Age	2 Numeric	Display Only	CMS Net Formulary File	MINIMUM AGE Minimum age requirement for the NDC.	
11	Max Age	2 Numeric	Display Only	CMS Net Formulary File	MAXIMUM AGE Maximum age requirement for the NDC.	
12	Min Qty	3 Numeric	Display Only	CMS Net Formulary File	MINIMUM QUANTITY Maximum quantity requirement for the NDC.	
12	Max Qty	3 Numeric	Display Only	CMS Net Formulary File	MAXIMUM QUANTITY Maximum quantity requirement for the NDC.	
13	Price Effective Date	10 Date	Display Only	CMS Net Formulary File	NDC PRICE EFFECTIVE DATE The price effective date.	
13	FAC	8 Numeric	Display Only	CMS Net Formulary File	FEDERAL AQU COST The FAC price.	
13	AWP	8 Numeric	Display Only	CMS Net Formulary File	ACTUAL WHOLE SALE PRICE The AWP price.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
13	MAIC	8 Numeric	Display Only	CMS Net Formulary File	MAIC PRICE The MAIC pric.	
13	EAC	8 Numeric	Display Only	CMS Net Formulary File	DIRECT PRICE The EAC price.	
13	Lowest Cost	8 Numeric	Display Only	CMS Net Formulary File	LOWEST COST The lowest price.	

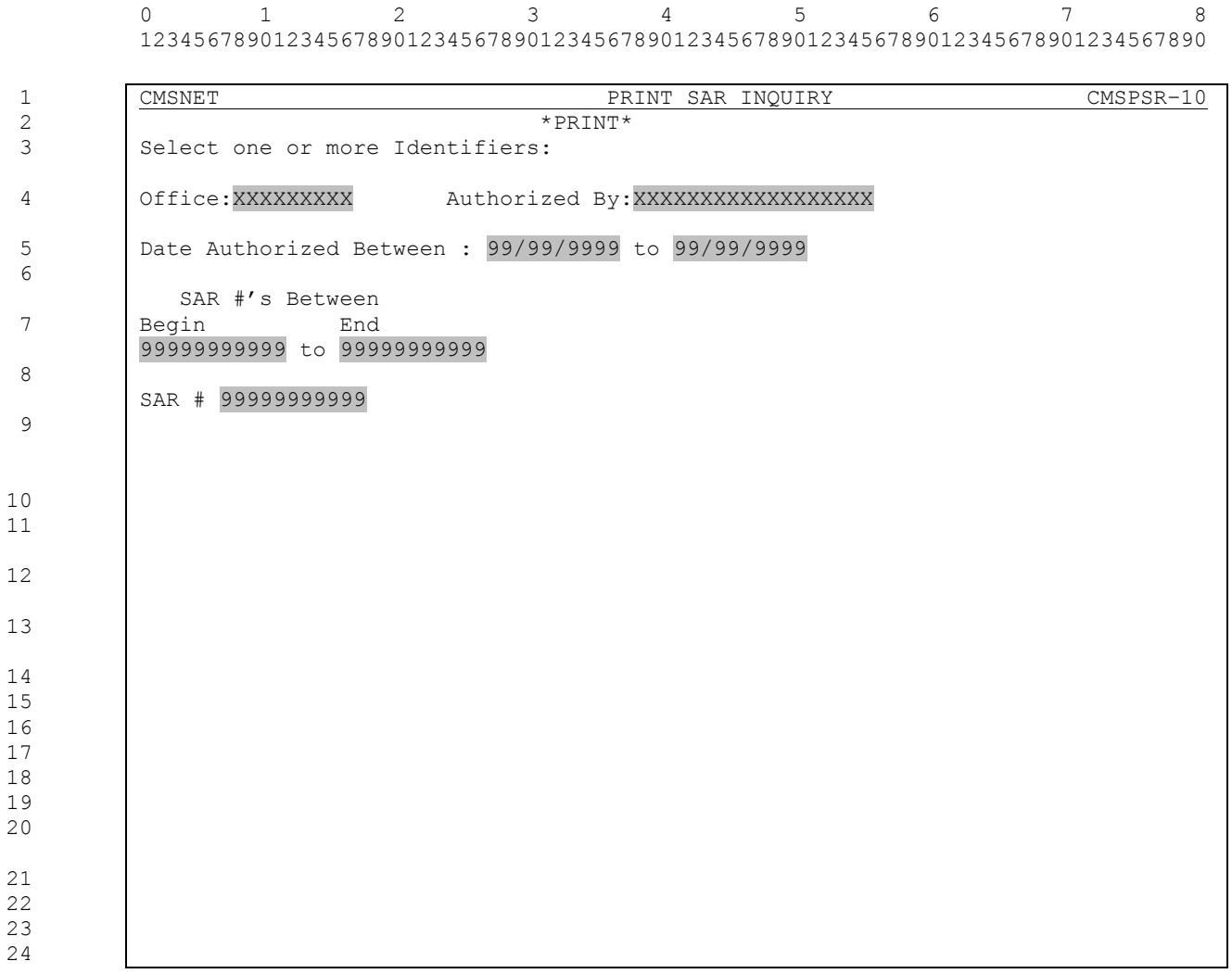
3.3.8 CMSPSR-10, Print SAR Inquiry

The CMSPSR-10 screen is used to initiate a query of Authorized SAR's in CMS Net. The screen includes the parameters that can be entered into CMS Net to evoke a search.

3.3.8.1Screen Reference Layout

Refer to Figure 3.8, CMSPSR-10 Screen layout, for a pictorial representation of the screen.

Figure 3.8, CMSPSR-10 Screen



3.3.8.2Screen Business Rules

The following business rules apply to the CMSPSR-10 Screen:

- This screen will be used to query the Authorized SAR's in CMS Net.
- At least one of the other fields must be completed to invoke the search.

3.3.8.3 Data Dictionary

Table 3.9 details each of the data fields that should be included on the CMSPSRI-10 screen, along with their attributes.

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Table 3.9, CMSPSR-10 Data Dictionary

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
5	Office	3 Alpha	Conditional	User input/CMS Net	OFFICE This field will allow the user to input the Field office the SAR was authorized. Values; CMS Net table	
5	Authorized By	40 Alpha	Conditional	User input/CMS Net	AUTHORIZED BY This field will allow the user to input the user who authorized the SAR. Values; CMS Net table	
7	SAR Begin	10 Date	Conditional	User input/CMS Net	SAR BETWEEN BEGIN DATE This field will allow the user to input the begin Date between the SAR was authorized between.	
7	SAR END	10 Date	Conditional	User input/CMS Net	SAR BETWEEN END DATE This field will allow the user to input the End Date between the SAR was authorized between.	
10	SAR's Begin #	11 Numeric	Conditional	User input/CMS Net	SAR NUMBER BEGIN NUMBER This field will allow the user to input the beginning SAR number.	

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
10	SAR's End #	11 Numeric	Conditional	User input/CMS Net	SAR NUMBER END NUMBER This field will allow the user to input the ending SAR number.	
13	SAR #	11 Numeric	Conditional	User input/CMS Net	SAR NUMBER This field will allow the user to input a SAR number.	

3.3.9 CMSPSR-20, Print SAR Summary

The CMSPSR-20 screen displays the results of a query of the Authorized SAR's in CMS Net.

3.3.9.1Screen Reference Layout

Refer to Figure 3.9, CMSPSR-20 Screen layout, for a pictorial representation of the screen.

Figure 3.9, CMSPSR-20

```
          0         1         2         3         4         5         6         7         8
          12345678901234567890123456789012345678901234567890123456789012345678901234567890

1         CMSNET                              PRINT SAR SUMMARY                    CMSPSR-20
2
3         SAR              Date Authorized      Provider     Clients
          Number                Between          Name         Name
4         99999999999  99/99/9999  99/99/9999  XXXXXXXXXXX  XXXXXXXXXXX
          99999999999  99/99/9999  99/99/9999  XXXXXXXXXXX  XXXXXXXXXXX
5         99999999999  99/99/9999  99/99/9999  XXXXXXXXXXX  XXXXXXXXXXX
6         99999999999  99/99/9999  99/99/9999  XXXXXXXXXXX  XXXXXXXXXXX
          99999999999  99/99/9999  99/99/9999  XXXXXXXXXXX  XXXXXXXXXXX
7         99999999999  99/99/9999  99/99/9999  XXXXXXXXXXX  XXXXXXXXXXX
          99999999999  99/99/9999  99/99/9999  XXXXXXXXXXX  XXXXXXXXXXX
8         99999999999  99/99/9999  99/99/9999  XXXXXXXXXXX  XXXXXXXXXXX
          99999999999  99/99/9999  99/99/9999  XXXXXXXXXXX  XXXXXXXXXXX
9         99999999999  99/99/9999  99/99/9999  XXXXXXXXXXX  XXXXXXXXXXX
          99999999999  99/99/9999  99/99/9999  XXXXXXXXXXX  XXXXXXXXXXX
10        99999999999  99/99/9999  99/99/9999  XXXXXXXXXXX  XXXXXXXXXXX
          99999999999  99/99/9999  99/99/9999  XXXXXXXXXXX  XXXXXXXXXXX
11        99999999999  99/99/9999  99/99/9999  XXXXXXXXXXX  XXXXXXXXXXX
          99999999999  99/99/9999  99/99/9999  XXXXXXXXXXX  XXXXXXXXXXX
12
13
14
15
16
17
18
19
20
21
22
23
24
```

3.3.9.2Screen Business Rules

The following business rules apply to this screen:

- This screen will display the results of a search of the Authorized SAR's in CMS Net.
- The screen will be display only. the records that fit the query parameters entered on the CMSPSR-10 screen.
- Users should be able to scroll the list of SAR's, select a SAR, and take the user to the CMSSAR-60 screen or return to the previous screen.

3.3.9.3 Data Dictionary

Table 3.10 details each of the data fields that should be included on the CMSPSR -20 screen, along with their attributes.

Table 3.10, CMSPSR-20 Data Dictionary

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
4	Office	20 Alpa	Display	CMS Net Table	OFFICE This field will allow the user to input the Field office the SAR was authorized.	
4	Begin Date	10 Date	Display	CMS Net	SAR BETWEEN BEGIN DATE This field is the begin Date between the SAR was authorized between.	
4	End Date	10 Date	Display	CMS Net	SAR BETWEEN END DATE This field is the user to input the end Date between the SAR was authorized between.	
4	Clients Name	40 Alpha	Display	CMS Net	CLIENTS LAST NAME The clients name on the SAR.	

3.3.10 CMSDCI-10, Dental Code Inquiry

The CMSDCI-10 screen displays the results of an inquiry of the CMS Net Dental Procedure Code table.

3.3.10.1 Screen Reference Layout

Refer to Figure 3.10, CMSDCI-10 Screen layout, for a pictorial representation of the screen.

Figure 3.10, CMSDCI-10 Screen

```
        0         1         2         3         4         5         6         7         8
        12345678901234567890123456789012345678901234567890123456789012345678901234567890

1       CMSNET                DENTAL PROCEDURE CODE INQUIRY SUMMARY              CMSDCI-10
2       Procedure
3       Code: Name:
        X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
4       X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
5       X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
6       X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
7       X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
8       X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9       X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
10      X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
11      X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
12      X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
13      X9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

14
15
16
17
18
19
20

21
22
23
24
```

3.3.10.2 Screen Business Rules

The following business rules apply to this screen:

- This screen will display the results of a search of the CMS Net Dental Procedure Code File table.
- All records that fit the query parameters entered on the CMSSARI-10 screen will be displayed on this screen if the user selected Dental Procedure Code in the Search For field
- The user will be able to select a code or return to the previous screen.
- Users should be able to scroll the list of codes, select a code, and take the user to the CMSDCI-20 screen.

3.3.10.3 Data Dictionary

Table 3.11 details each of the data fields that should be included on the CMSDCI-10 screen, along with their attributes.

Table 3.11, CMSDCI-10 Data Dictionary

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
4 – 21	Dental Procedure Code	5 Numeric	Display Only	CMS Net Table	DENTAL PROCEDURE CODE The dental procedure code.	
4 - 21	Dental Procedure Code Name	40 Alpha	Display Only	CMS Net Table	DENTAL PROCEDURE CODE NAME The dental procedure code name.	

3.3.11 CMSDCI-20, Dental Code Inquiry Detail

The CMSDCI-20 screen displays the detail results of a dental procedure code in CMS Net Dental Procedure Code table.

3.3.11.1 Screen Reference Layout

Refer to Figure 3.11, CMSDCI-20 Screen layout, for a pictorial representation of the screen.

Figure 3.11, CMSDCI-20 Screen

```
      0        1         2         3         4         5         6         7         8
      12345678901234567890123456789012345678901234567890123456789012345678901234567890

1     CMSNET          DENTAL PROCEDURE CODE INQUIRY DETAIL                  CMSDCI-20
2
3
      Dental Procedure Code:99999
4
      Effective Date: 99/99/9999
5
6     Min Age:99 Max Age:99 Max Freq:9 Xray:X  CCS:X
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
```

3.3.11.2 Screen Business Rules

The following business rules apply to this screen:

- This screen will display the detail results of a selected code in the CMS Net Dental Procedure Code File table.
- All information on the screen will be display only.

3.3.11.3 Data Dictionary

Table 3.12 details each of the data fields that should be included on the CMSDCI-20 screen, along with their attributes.

Table 3.12, CMSDCI-20 Data Dictionary

Line #	Field Name	Field Length/Type	Required?	Source	Description	Special Processing
4	Dental Procedure Code	5 Numeric	Conditional	User input/CMS Net Table	DENTAL PROCEDURE CODE The dental procedure code.	
6	Effective Date	10 Date	Conditional	User input/CMS Net Table	CODE EFFECTIVE DATE The effective date of the code.	
8	Min Age	1 Numeric	Conditional	User input/CMS Net Table	MINIMUM AGE Minimum age requirement for the code.	
8	Max Age	3 Numeric	Conditional	User input/CMS Net Table	MAXIMUM AGE Maximum age requirement for the code	
8	Freq	1 Numeric	Conditional	User input/CMS Net Table	FREQUENCY INDICATOR Frequency indicator for the code.	
8	Xray	1 Alpha	Conditional	User input/CMS Net Table	X RAY INDICATOR X Ray indicator for the code.	
8	CCS	1 Alpha	Conditional	User input/CMS Net Table	CCS INDICATOR CCS indicator for the code.	

4 SERVICE AUTHORIZATION FILE TRANSACTIONS

Under E47, the fiscal intermediaries will use authorization data to validate and adjudicate claims. In order to support the fiscal intermediary's claims processing functions, CMS Net must send data to the SAF at the medical and dental fiscal intermediaries for authorized, modified, canceled, and extended SAR transactions. These four transactions will provide the data elements necessary to populate the SAF. The table below identifies the SAF data elements and these transactions. The data elements and transactions are discussed in greater detail below.

Table 4-1, List of SAF Transactions and Associated Screens

Transaction Name	Source / CMS Screen
SAF File Data Elements	CMSSAR-60
Authorize	CMSSAR-60
Cancel	CMSSAR-80
Modify	CMSSAR-85
Extend	CMSSAR-90

The Authorize transaction will establish the initial record in the SAF, and will include all of the data initial elements required to establish a SAF record for the SAR. Modify, cancel, and extend transactions will change a previously established record (by the Authorize transaction) in the SAF.

This section presents the data elements which will be sent for each of the above transactions, along with their associated business rules.

4.1 AUTHORIZE TRANSACTION / SAF DATA ELEMENTS

CMS Net will send the fiscal intermediaries the following data elements for each authorized SAR. These data elements will establish the initial record of the authorization in the SAF. These data elements may be modified with a modification, extension, or cancellation transaction.

Table 4-2, Authorize Transaction / SAF Data Elements

Field Number	Field Name	Field Length/Type	Description
1.	Request Number	11 Numeric	REQUEST NUMBER CCS requests will have a pre-fix of 97. GHPP will have a prefix of 99. Digits in spaces 3 through 10 will be defined by CMS Net and shall be randomly and sequentially generated. 11th digit shall always be "0" For a new request the system will populate the field when Save is selected from the action menu.
2.	Request Status	10 Alpha	REQUEST STATUS Status of the medical request for service generated by the system. VALUES Authorized Denied Canceled Extended Modified
3.	Pricing Indicator / EPSDT indicator	1 Alpha	EPSDT-SS INDICATOR This field designates whether the authorization is for an EPSDT-SS. Values are Y (for Yes) or N (for No).
4.	Funding Category	9 Alpha	FUNDING CATEGORY Diagnosis, Treatment, Healthy Families, MTU
5.	County Code	2 Alpha	COUNTY CODE The client's legal county, derived from the client's face sheet. This code can be over written by users with a value of 59.
6.	CIN	11 Alpha Numeric	CLIENT INDEX NUMBER The individual's client index number.
7.	Provider Number	9 Alpha/Numeric	PROVIDER NUMBER The provider number (contained in the provider master file). Includes the special care center number.
8.	Service Begin Date	10 Numeric	SERVICE BEGIN DATE The beginning date the request for service is valid.

Field Number	Field Name	Field Length/Type	Description
9.	Service End Date	10 Numeric	SERVICE END DATE The date the request for service ceases to be valid.
10.	Number Of Days	3 Numeric	NUMBER OF DAYS VALUES The number of days the authorization is valid.
11.	Service Code	11 AN	SERVICE CODE The category of service, procedure, NDC code for the selected service. A minimum of one service must be included in the authorization transaction. Up to 60 service codes (with an associated quantity and number of units) can be selected for each authorization.
12.	Units	4 Numeric	SERVICE UNITS The maximum number of units for an authorized service.
13.	Quantity	4 Numeric	SERVICE QUANTITY The quantity per unit for an authorized service.
14.	Amount	8 Numeric	SERVICE AMOUNT The maximum allowed price of the service.
15.	Date	10 Date field	DATE The date the transaction is generated.

The following business rules apply to the SAF and the Authorize transaction:

- Service authorization data and transactions (authorize, cancel, extend, modify) will be electronically transmitted to EDS.
- The same data elements will be sent to both the dental and medical fiscal intermediaries. Delta Dental will not use the Funding Category and Service Amount. The same data elements will be sent by CMS Net, however, to simply the generation of the transaction. Delta Dental will strip these data elements from the transaction prior to updating the SAF.
- The SAF will be updated on an on-line, real time basis between the hours of 6:00 am and 6:00 pm Monday thorugh Friday. Transactions which are generated by CMS Net outside of this timeframe will be placed in a transaction queue and held until online transactions can be transmitted to the SAF.
- The fiscal intermediaries will use the service authorization data transmitted from CMS Net to the SAF to adjudicate claims. All claims will be billed with an authorization number. The adjudication process will include edits to verify the recipient, authorization period, and services authorized

- The fiscal intermediaries will be responsible for the maintaining the SAF (the file itself). CMS staff, using CMS Net, will be responsible for the data transmitted to the SAF.
- Only authorized SAR's will be sent to the SAF. Cancellation, modification, and extension transactions will be sent to the SAF to update the data elements of previously authorized requests.
- CCS/GHPP staff will be allowed to query the SAF by client ID (CIN) or authorization number. This ability will be provided through EDS Net / CAMMIS rather than CMS Net.
- Services on the authorization will be entered with service codes. Up to 60 service codes will be sent to EDS on a single authorization. These codes will be transmitted to EDS and included in the SAF.
- The authorized provider on request for service must be the billing, rendering or referring provider. Assistant surgeons must bill with the primary surgeon's number as the referring provider.
- EDS will purge service authorizations from the online SAF file after three years, based on the Service End Date. The purged records will be written to the Service Authorization Purged File maintained at EDS. Procedures will be established to access purged records.
- The requirements for purging dental authorization data will be determined.
- The SAF will contain service authorizations for both CCS and GHPP. These specifications, however, only pertain to CCS service authorizations.
- CCS/GHPP claims authorized before implementation will adjudicate through the current claims processing process. The SAF will not be populated by authorizations generated prior to the implementation of E47.
- All CCS/GHPP authorization numbers will be 11 digits. The first two digits will be either '97' for CCS authorizations or '99' for GHPP authorizations. Digits three through ten will be defined by CMS Net. The eleventh digit will always be zero.

4.2 CANCEL TRANSACTION

Table 4-3 identifies the data elements that will be sent with a cancel transaction.

Table 4-3, SAF Cancel Transaction

Field Number	Field Name	Field Length/Type	Description
1.	Request Number	11 Numeric	REQUEST NUMBER The number of the request that has been canceled.
2.	Request Status	10 Alpha	REQUEST STATUS Status of the medical request for service generated by the system. VALUES Canceled
3.	Service End Date	10 Date	SERVICE END DATE The end date of the request. This date will equal the Date Canceled field on the CMSSAR-80 screen.
4.	Date	10 Date field	DATE The date the transaction is generated.

The following business rules apply to the cancel transaction:

- Cancel transactions to the SAF will be generated by the CMSSAR-80 screen.
- SAR's will be canceled at the fiscal intermediaries by changing the Service End Date. To accomplish this, CMS Net will modify the Service End Date to equal the date that the authorization is cancelled, based on the Effective Date field of the CMSSAR-80 screen.

4.3 MODIFY TRANSACTION

Table 4-4 identifies the data elements that will be sent to the SAF with a modify transaction.

Table 4-4, SAF Modify Transaction

Field Number	Field Name	Field Length/Type	Description
1.	Request Number	11 Numeric	REQUEST NUMBER The number of the request that has been modified.

Field Number	Field Name	Field Length/Type	Description
2.	Request Status	10 Alpha	REQUEST STATUS Status of the medical request for service generated by the system. VALUES Modified
3.	Service Code	11 AN	SERVICE CODE The category of service, procedure, NDC code for the selected service. A minimum of one service must be included in the authorization transaction. Up to 60 service codes (with an associated quantity and number of units) can be selected for each authorization.
4.	Units	4 Numeric	SERVICE UNITS The maximum number of units for an authorized service.
5.	Quantity	4 Numeric	SERVICE QUANTITY The quantity per unit for an authorized service.
6.	Amount	8 Numeric	SERVICE AMOUNT The maximum allowed price of the service.
7.	Date	10 Date field	DATE The date the transaction is generated.

The following business rules apply to the modify transaction:

- Modify transactions to the SAF will be generated by the CMSSAR-90 screen.

4.4 EXTEND TRANSACTION

The following data elements will be sent from CMS Net to the SAF in an extend transaction.

Table 4-5, SAF Extend Transaction

Field Number	Field Name	Field Length/Type	Description

Field Number	Field Name	Field Length/Type	Description
16.	Request Number	11 Numeric	REQUEST NUMBER CCS requests will have a pre-fix of 97. GHPP will have a prefix of 99. Digits in spaces 3 through 10 will be defined by CMS Net and shall be randomly and sequentially generated. 11th digit shall always be "0" For a new request the system will populate the field when Save is selected from the action menu.
17.	Request Status	10 Alpha	REQUEST STATUS Status of the medical request for service generated by the system. VALUES Authorized Denied Canceled Extended Modified
18.	Pricing Indicator / EPSDT indicator	1 Alpha	EPSDT-SS INDICATOR This field designates whether the authorization is for an EPSDT-SS. Values are Y (for Yes) or N (for No).
19.	Funding Category	9 Alpha	FUNDING CATEGORY Diagnosis, Treatment, Healthy Families, MTU
20.	County Code	2 Alpha	COUNTY CODE The client's legal county, derived from the client's face sheet. This code can be over written by users with a value of 59.
21.	CIN	11 Alpha Numeric	CLIENT INDEX NUMBER The individual's client index number.
22.	Provider Number	9 Alpha/Numeric	PROVIDER NUMBER The provider number (contained in the provider master file). Includes the special care center number.
23.	Service Begin Date	10 Numeric	SERVICE BEGIN DATE The beginning date the request for service is valid.

Field Number	Field Name	Field Length/Type	Description
24.	Service End Date	10 Numeric	SERVICE END DATE The date the request for service ceases to be valid.
25.	Number Of Days	3 Numeric	NUMBER OF DAYS VALUES The number of days the authorization is valid.
26.	Service Code	11 AN	SERVICE CODE The category of service, procedure, NDC code for the selected service. A minimum of one service must be included in the authorization transaction. Up to 60 service codes (with an associated quantity and number of units) can be selected for each authorization.
27.	Units	4 Numeric	SERVICE UNITS The maximum number of units for an authorized service.
28.	Quantity	4 Numeric	SERVICE QUANTITY The quantity per unit for an authorized service.
29.	Amount	8 Numeric	SERVICE AMOUNT The maximum allowed price of the service.
30.	Date	10 Date field	DATE The date the transaction is generated.

The following business rules apply to the extend transaction:

- Extend transactions to the SAF will be generated by the CMSSAR-85 screen.

5 TABLE AND FILE MAINTENANCE

The selection of providers and services will be supported by several tables and files which will be downloaded to CMS Net. These tables and files will support lists that users will scroll to select providers and services. The tables and files will also have data elements which CMS Net will use to apply edits to the selection of providers and services to ensure that these selections are consistent with CCS program and policy rules.

This section presents information on these tables and files, and describes in greater detail how they will be used in CMS Net. Business Rules

5.1 TABLE AND FILE BUSINESS RULES

The following business rules apply to the tables and files that will be downloaded into CMS Net:

- Most of the tables and files identified in this subsection will are based on Medi-Cal and Denti-Cal tables and files. Therefore, the source tables will reside at the fiscal intermediaries and will be downloaded to CMS Net. Updates to the tables will be made as necessary, whenever applicable changes are made to the source table at the fiscal intermediary. These updates should be made as soon as possible after they were made to the source tables and files. This will minimize version control issues, and reduce the potential for users to select invalid service codes.
- Additional tables may be identified and added to CMS Net during the detailed design phase, especially as a part of the GUI screen presentation (in order to translate fields whose value in the database is a code to text which is displayed on the screen).
- The standard process of OILS (Medi-Cal) and DOILS (Denti-cal) will be used to change table values. All OILS and DOILS impacting the tables downloaded to CMS Net will be routed to CMS so that the impact of the changes on CCS can be assessed.

5.2 OVERVIEW OF REQUIRED TABLES

Table 5-1 lists the tables and files that must be downloaded to CMS Net to support the processing of authorizations. The Source column on the table indicates whether the table reside at EDS or Delta Dental. The Resp column indicates whether the source of the data on the table will be Delta Dental, EDS, or CMS.

Table 5-1, Authorization Tables and Files

Table / File Name	Description	Usage in CMS Net	Source	Resp
Table 4200 – Category of Service to Provider Type	• Lists provider types and the applicable categories of service for which the provider types re eligible.	• Used to associate provider types with their categories of service. Authorizations must only include category of service codes which are applicable to the provider selected for the authorization.	EDS	EDS
Table 4201 – Procedure Code to Category of Service	• Lists procedure code ranges allowed for each category of service.	• Used to associate specific procedure codes to a category of service. Specific procedure codes can only be included in an authorization if they are within a provider's category of service.	EDS	EDS
Procedure File	• Provides a detailed listing of all procedure codes. Includes edits such as the dates that the code is valid; patient gender and age restrictions, and pricing. • Contains additional details on procedure codes. These details are not included in the 4201 table.	• Used by CMS Net to apply edits to the procedure codes selected by users in order to determine whether the code is valid and can be included in an authorization or if the code is invalid for the authroization an error message should be displayed. • Used to populate the code and decription fields on the authorization screens.	EDS	EDS
Formulary (Drug) Information	• A new file which will be developed and and downloaded to CMS Net. Data elements will be excerpted from the COINS Database	• Used to populate the code and descripition fields on the authorization screens when a drug code is selected. • Used by CMS net to apply edits to the drug codes selected by users. This will ensure that the codes are valid and can be included in the authorization.	EDS	EDS
CCS Categories of Service Table	• Defines CCS only categories of service • Format similar to the 4201 table • Table does not currently exist, format and data elements must be defined. • Table will be stored at EDS, downloaded to	• Will be used to define the CCS medical categories of service that are not currently covered by Medi-Cal but which are covered by CCS. • This table is necessary because the tables (and their associated tables) listed above	EDS	CMS

	CMS Net.	are adapted from Medi-Cal. These tables do not include CCS category of service codes.		
Drugs Requiring Specific Authorizations	• Defines drugs which cannot be included in a category of service / special care center authorization. These drugs require a separate and specific authorization.	• Used to populate the code and descripition fields on the authorization screens when a drug code is selected. • Used by CMS net to apply edits to the drug codes selected by users. This will ensure that the codes are valid and can be included in the authorization.	EDS	CMS
Dental Procedure Codes	• Provides a detailed listing of all dental procedure codes. Includes edits such as the dates that the code is valid; applicable teeth; etc.	• Used to populate the code and descripition fields on the authorization screens when a dental procedure code is selected. • Used by CMS net to apply edits to the drug codes selected by users. This will ensure that the codes are valid and can be included in the authorization.	DD	DD
Dental Procedure Code Translation Table	• Cross references 3,4, and 5 digit dental procedure codes.	• Some dental procedures have multiple codes. Different, 3,4, and 5 digit dental procedure codes can be used to denote the same procedure. This table cross-references the 3,4, and 5 digit codes so that users can use a 3, 4, or 5 digit code to select a single procedure.	DD	DD
Dental Procedure Code Groups	• Groups individual dental procedure codes so that all codes within the group can be authorized with a single service code (similar to category of service codes).	• Used for the selection of dental procedure code groups.	DD	CMS

5.3 TABLE DATA ELEMENTS / FORMATS

The subsections which follow provide additional information on the tables referenced above. The information includes the specific data elements and / or field lengths of the tables.

5.3.1 Table 4200 – Category of Service to Provider Type Table

This table will include two subsets of data. Format 01: Lists provider types and the applicable categories of service for which the provider types are eligible. Format 02: Lists the categories of service and the vendor code used for reporting purposes.

Format 01

01- 04	Table ID (4200)
05 - 06	Provider Type
07- 10	Blank
11 - 12	Format = Always 01
13 - 80	Categories of Service (2 positions separated by a comma)

Format 02

01 - 04	Table ID (4200)
05 - 06	Provider Type
07- 10	Blank
11 - 12	Format = Always 02
13 - 14	Categories of Service (definition is as follows)*
15 - 16	Vendor Code (definition is as follows)*
17	Blank

*Columns 13 -17 repeat as necessary up 13 entries not to exceed column 80. The first two positions are the category of service (for the defined provider type) which will report to the appropriate vendor code (column 15 -16). If all categories are to report to only one vendor code, the first two positions should be 00.

5.3.2 Table 4201 – Procedure Code to Category of Service Table

This MMIS table contains procedure ranges allowed for each category of service listed.

Column	Description
01 - 04	Table ID (4201)
05 - 10	Identifies the following: I = SMA/CRVS/CSN Procedure Codes 2 = Modifiers 3 = LTC Accommodation Codes 4 = Ancillary Codes 5 = Medical Supply Codes
11 - 12	Format = Always 00
13 - 17	Ending Procedure
18- 19	Blank
20 –22	Primary category of service if applicable and a comma (for sorting; if no sorting is necessary, 00)
23-80	Lists the categories of service (2 digits each, followed by a comma)

5.3.3 Procedure File

The following data elements will be downloaded to CMS Net from the procedure file:

Data Element / Field Name

- Type
- Procedure
- Name
- Status Begin Date
- Status End Date
- Sex
- Age Min
- Age Max
- Max Uvsp indicator
- Diagnostic Range
- Date (p/d indicator)
- P/D indicator
- TAR indicator
- I/E indicator
- Place of service
- (Basic Units)Pricing – see below
- Conv ind
- From date
- Thru date
- Unit

- Price

5.3.4 Formulary File

The following data elements should be downloaded from the formulary file:

Data Element / Field Name

- Primary CD
- Label
- Gener
- Sex
- TAR Ind
- PMT Ind
- Drug Ind
- Code 1 ind
- Disp Fee
- Lgn Ind
- Unit Desc
- Min Age
- Max Age
- Min Qty
- Max Qty
- Days Supply Min
- Days Supply Max
- Pricing – See below
- Date
- Ind
- FAC
- AWP
- MAIC
- EAC
- Lowest Cost

5.3.5 Drugs Requiring Specific Authorizations

This table will denote drugs which require a specific authorization from CCS. The following presents a specific listing of these drugs. The list below is included for references purposes and may change prior to implementation. The list, therefore, should be updated immediately prior to implementation. After the list is updated and placed in production, subsequent changes to the list should be made through the OIL process.

Drugs Requiring Specific Authorization

I. Numbered letter drugs

Code	Description
J-1955	Carnitine
X-6836	Epogen
X-7030	Procrit
J-1620	GnRH-agonists
J-1565	RSV Immune Globulin
X-7438	RSV Immune Globulin Pulmozyme
J-1561	Immune Serum Globulin
J-1562	Immune Serum Globulin
X-6230	Immune Serum Globulin
X-6232	Immune Serum Globulin
X-6234	Immune Serum Globulin
X-7452	Nutropin
X-7454	Nutropin
X-7034	Somatrem (Protropin)
X-7036	Somatropin (Humatrope)
X-7439	Synagis

II. Other drugs needing prior authorization:

J-0476	Intrathecal Baclofen
J-0585	Botulinum Toxin Type A
X-7040	Botulinum Toxin Type A
X-7042	Botulinum Toxin Type A
X-7044	Botulinum Toxin Type A
J-7190	Factor VIII (human)
J-7191	Factor VIII (porcine)
J-7192	Factor VIII, recombinant
J-7194	Factor IX complex
J-7196	Other hemophilia clotting factors

J-7197	Antithrombin III (human)
X-7712	Recombinant Antihemophilic Factor
X-5230	Factor VIIa, recombinant (NovoSeven)

These drugs should be included in a table that includes the same data elements as the current MMIS Table 0547 Prescription Limit Exclusion Table. The format for this table is presented below for reference purposes. This format should be validated and changed as necessary prior to development.

MMIS Table 0547 – Prescription Limit Exclusions

Column	Description
01 – 04	Table ID (required)
05 – 10	Sequence Number
11 – 12	Format, always '01' (required)
13	Blank
14	Include/Exclude Indicator (required)
15	Blank
16 – 39	Excluded Smart*Key with Wildcard characters (required)
40	Blank
41 – 48	Range Begin Date (required)
49	Blank
50 – 57	Range End Date (required)
58	Blank
59 – 80	Description (optional)

5.3.6 Dental Procedure Codes

Dental services will be selected from a table which contains valid procedure codes for dental services. Appendix C presents the data elements that should be included on the table.

5.3.7 Dental Procedure Code Translation Table

Appendix D presents the procedure code translation table. This table will allow users to enter 3, 4, or 5 digit procedure codes to denote the dental services. The table will cross reference different procedure codes which relate to the same service.

5.3.8 Dental Code Groups

A key CMS Net requirement which must be met is the ability to authorize dental services in groups. These dental service code groups will function (conceptually) in a manner similar to medical category of service codes. As such, CMS Net should provide the ability to issue an authorization with a single code that covers multiple services. The codes should be grouped an a table which can be easily modified based on changes in program policy. This table should be made available to both CMS Net for authorization purposes, and Delta Dental for claims processing.

The following tables identify the codes which should be included in each group.

Table 1, Preventive Dental Services

Code	Description	Denti-Cal	CCS
010, 015	Examinations		
049, 050	4 prophylaxes per year		
or 061, 062	4 prophylaxes with fluoride tx.		
041, 042, 043, 044, 045, 046	Sealants		
116, 117	Bitewing xrays *AND/OR*		
110, 111	Periapical x-rays *OR*		
112 or 125	Intraoral x-rays – complete series ***or*** panographic film		

Table 2, Year One, Orthodontic Services for Medically Handicapping Malocclusion

Code	Description	Denti-Cal	CCS
125	Panographic-film. Single radiograph		
552	Banding and materials		
554	Treatment visit		
557	Diagnostic work up and photos		
558	Study models		
956, 957	Cephalometric head film		

Table 3, Year Two, Orthodontic Services for Medically Handicapping Malocclusion

Code	Description	Denti-Cal	CCS
554	Treatment visit		

Table 4, Year Three, Orthodontic Services for Medically Handicapping Malocclusion

Code	Description	Denti-Cal	CCS
112 or 125	Intraoral complete series OR panographic film		
119, 120	Photograph or slide		
556	Quarterly observations		
559	Retainer, one each, upper and lower		
956, 957	Cephalometric head film		

Table 5, Year Four, Orthodontic Services for Medically Handicapping Malocclusion

Code	Description	Denti-Cal	CCS
556	Quarterly observations		
558	Study models		

Table 6, Primary Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services

Code	Description	Denti-Cal	CCS
112 or 125	Intraoral complete series OR panographic film		
119, 120	Photograph or slide		
558	Study models		
560	Diagnostic work up		
562	Banding and materials		
564	Treatment visits		
599	Retainer, one each, upper and lower		
956, 957	Cephalometric head film		

Table 7, Mixed Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services

Code	Description	Denti-Cal	CCS
112 or 125	Intraoral complete series OR panographic film		
119, 120	Photograph or slide		
556	Quarterly Observations		
558	Study models		
570	Banding and materials		
572	Treatment visits		
599	Retainer, one each, upper and lower		
956, 957	Cephalometric head film		

Table 8, Permanent Dentition for Cleft Palate and/or Cleft Lip Orthodontic Service for Year 1

Code	Description	Denti-Cal	CCS
112 or 125	Intraoral complete series OR panographic film		
119, 120	Photograph or slide		
580	Banding and materials		
582	Treatment visits		
956, 957	Cephalometric head film		

Table 9, Permanent Dentition for Cleft Palate and/or Cleft Lip Orthodontic Service for Year 2

Code	Description	Denti-Cal	CCS
582	Treatment visits		

Table 10, Permanent Dentition for Cleft Palate and/or Cleft Lip Orthodontic Service for Year 3

Code	Description	Denti-Cal	CCS
Code	Description	Denti-Cal	CCS
112 or 125	Intraoral complete series OR panographic film		

119, 120	Photographs or slides		
556	Quarterly observations		
558	Study models		
582	Treatment visits		
599	Retainer, one each, upper and lower		
956, 957	Cephalometric head film		

Table 11, Permanent Dentition for Cleft Palate and/or Cleft Lip Orthodontic Service for Year 4

Code	Description	Denti-Cal	CCS
556	Quarterly observations		

Table 12, Facial Growth Management Services

Code	Description	Denti-Cal	CCS
112 or 125	Intraoral complete series OR panographic film		
119, 120	Photographs or slides		
556	Quarterly observations		
558	Study models		
590	Diagnostic work up		
592	Quarterly observations (pre-treatment visits)		
594	Progress records prior to treatment		
596	Banding and materials		
598	Treatment visits		
599	Retainers – removable one each, upper and lower		
956, 957	Cephalometric head film		

Table 13, Primary Teeth Restorative Dental Services

Code	Description	Denti-Cal	CCS
600, 601, 602, 603	Amalgam		
645, 646	Composite restorations		
501	Therapeutic pulpotomy		

Table 14, Permanent Teeth Restorative Dental Services

Code	Description	Denti-Cal	CCS
502	Therapeutic pulpotomy		
611, 612, 613, 614	Amalgam		
645, 646	Composite restorations		

Table 15, Periodontic Services

Code	Description	Denti-Cal	CCS
452	Subgingival curettage and root planing		
472 or 473	Gingivectomy or gingivoplasty per quadrant OR osseous and mucogingival surgery per quadrant		
474	Gingivectomy or gingivoplasy, treatment per tooth (fewer than 6 teeth)		

Table 16, Removable Prosthetic Services

Code	Description	Denti-Cal	CCS
700, 701	Complete denture		
702/712	Partial denture		

703/704 708/709			
706/716	Stayplate/Clasp		

Table 17, Fixed Prosthetic Services

Code	Description	Denti-Cal	CCS
660, 653	Lab processed crowns		
672	Cast metal dowel post		
680, 681, 682, 692, 693	Fixed Bridge Pontic		

Table 18, Dental Services under Conscious Sedation or General Anesthesia

Code	Description	Denti-Cal	CCS
010, 015	1 examination		
049, 050	1 prophylaxis OR		
Or 061, 062	1 prophylaxis with fluoride treatment		
041, 042, 043, 044, 045, 046	Sealants		
116, 117	Bitewing x-rays ***and/or***		
110, 111	Periapical x-rays ***or***		
112 or 125 (1)	Intraoral x-rays – complete series ***or*** panographic film		
200, 201, 202, 203, 204, 230, 231, 232	Removal of erupted tooth Removal of root tip, Removal of unerupted tooth		
301 or 400	Conscious sedation, General anesthesia		
451, 452, 472, 474	Periodontics including emergency treatment, subgingival curettage and root planing, gingivectomy or gingivoplasty		
501, 502, 511, 512, 513, 530	Pulpotomy, root canal therapy, apicoectomy		
600, 601, 602, 603, 611, 612, 613, 614	Amalgam restorations		
645, 646, 648	Composite or plastic restoration, pin retention		
670, 671,	Stainless steel crown		
800, 811, 812	Fixed space maintainer		

6 MEDICAL AND DENTAL BUSINESS RULES

The screens, flows, and functions of the authorization component of CMS are based on a series of medical and dental business rules that were developed and agreed upon by all key stakeholders involved in the CMS Net E47 project. These business rules effectively function as the high level requirements which guide the design and development of the authorization component. The Medical and Dental business rules are contained in Appendix A and B, respectively.

APPENDICES

Appendix A: Medical Business Rules

Appendix B: Dental Business Rules

Appendix C: Dental Procedure Code Table

Appendix D: Dental Procedure Code Translation Table

APPENDIX A

BUSINESS REQUIREMENTS FOR AUTHORIZATIONS AND CLAIMS PROCESSING RULES

PRIMARY CARE AND FAMILY HEALTH DIVISION
CHILDREN'S MEDICAL SERVICES BRANCH

CMS NETWORK/ENHANCEMENT 47
HIGH LEVEL BUSINESS REQUIREMENTS FOR MEDICAL SERVICES AUTHORIZATIONS AND CLAIMS PROCESSING

REVIEW AND ACKNOWLEDGE

CHILDREN'S MEDICAL SERVICES BRANCH

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Terry Daffin

Date: _____

Elizabeth H. Lyman

INFORMATION TECHNOLOGY SYSTEMS DIVISION

Date: _____

Kathy Sabel

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Carol Tetz

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Darlene Little

Date:

Ted Spelis

ELECTRONIC DATA SYSTEMS

Date:

Chris Clausen

Date:

Rod Bottel

MEDICAL SERVICES

BUSINESS REQUIREMENTS FOR AUTHORIZATIONS AND CLAIMS PROCESSING

REQUIREMENTS

1. Create a CCS/GHPP Category of Service (COS) table that will allow for modification to the COS as it is defined currently on the 4201 table. The table will allow the flexibility to include and exclude codes, for CCS/GHPP purposes, that are currently on the 4201 table.

2. The new table(s) must allow for the inclusion or exclusion of Modifiers, Inpatient Accommodation Codes, Ancillary Codes, and HCPCS Codes, NDCs and Smart*Keys.

3. Transmit the 4200, 4201, the new CCS/GHPP Category of Service table(s) and any additional tables associated with category of service and procedure codes identified to CMS in order to keep the systems in sync. Transmit full replacement file to CMS on an automated weekly basis. Transmit all tables as a single file.

4. Allow CCS/GHPP to query the CCS/GHPP Service Authorization File (SAF) by client id (CIN) or Authorization number.

5. Edit all CCS/GHPP authorized claims against the CCS/GHPP Service Authorization File (SAF) to verify recipient, authorization period, and services authorized.

6. For Code Specific Authorizations, the authorized provider must be the billing, rendering or referring provider (in the case of assistant surgeon, bill with primary surgeons number as the referring).

7. Allow the CCS/GHPP Service Authorization File (SAF) to decrement when Code Specific claims are paid. Do not decrement when an assistant surgeon bills for the code.

8. An authorization for Inpatient hospital claims will be by number of "Days" within a specified period for a specific provider and default to Acute Days. Providers will be paid at the level they bill and be subject to Medi-Cal edits and audits for level of care. Providers rendering care in the hospital will require their own authorization.

9. For COS authorizations only: Any provider with the same COS as the authorized provider can bill against the authorization unless the authorization is for a special care center. The other providers will get the authorization number from the authorized provider. This does not apply to SCC's.

10. Special Care Center authorizations: Authorize each member of the center for their COS. Non-center providers, except for labs, pharmacies and radiology, cannot use these authorizations. The referring provider number on these claims must be a member on the authorized SCC.

11. Price the claim according to current CCS/GHPP rate policy. Allow for negotiated priced authorizations for services that do not have a price on file.

12. Create appropriate edits and audits for CCS/GHPP authorized claims. Any changes that affect Medi-Cal scope of benefits will be addressed through the OIL process, not as part of E47.

13. CCS/GHPP will follow Medi-Cal rules for CIF's, appeals and adjustments. EDS will provide recommendations on any variation from the current CIF, Appeal and Adjustment procedures for CCS/GHPP claims.

14. Allow Pharmacies to submit appropriate CCS/GHPP claims to be adjudicated through CALPOS using the Physicians COS authorization.
15. Transmit the procedure file to CMS. The schedule of the transmit and the file and/or extract layout will be finalized at a later point in the design process.

16. Transmit the formulary file to CMS. The schedule of the transmit and the file and/or extract layout will be finalized at a later point in the design process.

17. The rendering, referring or authorized provider must have the known to CCS indicator on the Provider Master file in order to be reimbursed.

18. There will be a data element in the authorization that can override the legal county on the HAP file for the recipient. This is to address claims paid out of general funds e.g. county code 59.

19. The CCS/GHPP authorization will override the same limitations in CALPOS as a Medi-Cal TAR including but not limited to: 6 prescription limits, end dated drugs, drugs not on the list of contract drugs and code 1 restrictions.

20. CCS/GHPP authorizations will not override a 'TAR 2 limitation' on the formulary file (CALPOS or paper claims). This limitation is for drugs that Medi-Cal will not pay such as blood factors that have a corresponding procedure code.

21. The county override code needs to be reported on the claim record for funding purposes.

22. For Medi-Cal funded claims authorized by CCS/ GHPP, if the claim would pay without a TAR under the Medi-Cal program but fails edits for the CCS/GHPP Service Authorization the claim will deny.

23. The entire claim for inpatient claims or claim line for all other claim types will pay out of CCS/GHPP funds when it is authorized with a quantity greater than Medi-Cal allows or if it exceeds Medi-Cal frequency. Create a report to review how much CCS/GHPP is paying.

24. A claim will only be processed as EPSDT-SS if it is authorized as such. If a claim is beyond the scope of Medi-Cal and not authorized as EPSDT-SS, it will be paid out of CCS/GHPP funds.

ASSUMPTIONS

1. All CCS/GHPP claims shall be billed with a Service Authorization Number.
2. All authorizations shall be issued to hospitals, individual physicians, DME dealers, etc. or special care centers.
3. All CCS/GHPP client ID's will be on MEDS.
4. An authorization will not override lack of client eligibility on MEDS and/or HAP.
5. CCS/GHPP aid codes will be on the HAP file.
6. All authorizations will have a begin and end date.
7. CCS/GHPP claims authorized before implementation will adjudicate through the current claims processing process.
8. The CCS/GHPP Provider Types (080, 081) and COS (098, 099) will be phased out along with the CGP numbers. Claims for these provider numbers will adjudicate with the current claims processing process.
9. All CCS/GHPP providers will be on the Provider Master File (PMF) (medical and dental respectively).
10. All providers will have a provider type and category of service that defines their scope of services on the Provider Master File. This includes CCS/GHPP providers with the CMS prefix only; they do not have a Medi-Cal provider number.
11. The provider type of the authorized provider will drive the services on the authorization. This does not apply to Special Care Centers.
12. The Special Care Center association indicator will be on a trailer screen on the PMF for each provider. The SCC number will define if the provider is a core team member or a consulting member of each SCC.
13. All authorizations are client specific. Billing for testing of an organ donor for compatibility with a client or genetic testing of parents/siblings of a client that is associated with providing

diagnostic or treatment services for the client shall follow Medi-Cal billing guidelines and use the client's eligibility.

14. Authorizations can be authorized Code specific and COS for the same provider.

15. Must be able to authorize Pharmacy authorizations by drug name.

16. Inpatient hospital authorizations will only include Inpatient "Days".

17. CCS/GHPP authorization numbers will be 11 digits.

18. CCS Authorizations will have prefix 97.

19. GHPP Authorizations will have prefix 99.

20. The authorization will contain a reporting category to identify if it is a treatment, diagnosis, or therapy authorization. The CCS case manager will define the reporting category.

21. The authorization will contain a unique sequencing number.

22. The authorization will contain a Julian date.

23. The authorization number will contain a pricing indicator that will identify EPSDT-SS and price negotiated authorizations. This is a dual-purpose indicator.

24. Post processing reporting will be handled separately.

25. CCS/GHPP will update the CCS/GHPP Categories of Service table with an OIL.

26. Coordination with the provider phase of enhancement 47 will be required for successful implementation.

27. All future OIL's that generate edit criteria must be routed through CCS/GHPP to determine if the error code should apply to CCS/GHPP claims or not.

28. CCS in conjunction with EDS change support will translate NDCs into Smart*Keys for the CCS/GHPP COS table for whole groups of drugs.

29. There will be ongoing review of Medi-Cal edits/audits by CCS to determine those that should be or should not be overridden for claims that are authorized by CCS/GHPP. Review claims that suspend for keying errors and follow instructions for CCS/GHPP claims.

30. CCS/GHPP funds are to pay out of the appropriate state or county allocation fund.

31. The requirements in these business rules are for CCS/GHPP users. They do no limit system functionality needed for fiscal intermediary purposes.

32. A claim line cannot be reported on two payment tapes. One claim line cannot be paid out of two funding sources.

33. These E47 business rules do not override any existing Medi-Cal policy.

34. CCS/GHPP pharmacy claims must follow Medi-Cal rules for CALPOS (i.e. no special CCS fields, etc.)

35. CCS covers procedure codes that are not Medi-Cal benefits.

36. A code specific authorization could be procedure code, procedure code with modifier, accommodation codes and NDC's.

37. CCS/GHPP does not need to receive the diagnosis file or the smart-key file.

38. CCS/GHPP is responsible for oversight of utilization control and for ensuring the integrity of CCS/GHPP approved providers who are granted authorization for services and the resulting claims. CCS/GHPP will create and maintain the oversight and management reports necessary for performance of these functions.

6.1 REQUIRED ELEMENTS OF CCS/GHPP SERVICE AUTHORIZATION FILE

1. Authorization number
   - Prefix
2. Reporting Category

3. Pricing indicator/EPSDT indicator

4. County code

5. Date is was created in Julian date format

6. Recipient ID
   - CIN

7. Begin and End date
   - Period the authorization is valid

8. Provider number
   - Must be on PMF
   - If a claim is billed with a specific code, the billing, rendering or referring provider number (in the case of assistant surgeon) must match the authorized provider number
   - Does not have to match claim provider number if it is authorized for COS
   - If a claim is billed with an authorization from a Special Care Center, provider number on the claim must be associated with the SCC

Data Elements that can be on the Service Authorization File

9. Category of Service
   - All providers have a COS
   - Authorization provider number does not have to match claim provider number
   - Billing, rendering, prescribing or referring provider must have the same COS as the authorized provider
   - Service billed must be part of COS authorized
   - These services will be defined on the new CCS/GHPP COS table
   - No quantity restrictions

10. Code Specific
    - Can be one of the following codes:
    - HCPCS Codes with or without a modifier

- NDC
- Accommodation Codes
- Ancillary Codes
- Medical Supply
- Billing, rendering or referring provider number on the claim must match the authorized provider number.
- Will always have a quantity
- Will decrement the authorization file when used
- Assistant surgeon claim will not decrement authorization
- Any provider associated the authorized SCC can bill for the Code and authorization will decrement
- Can override any limitations on the COS
- Can override any modifier limitations for that procedure
    - *Example* – a surgical procedure may not allow for an assistant surgeon for Medi-Cal but a CCS client may have medical complications that require an assistant surgeon for the procedure. This service would be authorized with the procedure code and procedure code/ modifier.

11. Inpatient Hospital Facility
    - Will have a quantity
    - Will default to Acute days
    - Will decrement the authorization file when used

12. Special Care Center Authorizations (SCC)
    - Authorized to the Special Care Center
    - Provider number on claim must be associated with SCC
    - Authorizes each center member for their COS (this cannot be used by non-SCC providers)
    - Provider association with a SCC will be from the PMF
    - Lab, Radiology and Pharmacy services as defined CCS/GHPP COS table

APPENDIX B

DENTAL BUSINESS RULES

PRIMARY CARE AND FAMILY HEALTH DIVISION
CHILDREN'S MEDICAL SERVICES BRANCH

CMS NETWORK/ENHANCEMENT 01
DENTAL BUSINESS RULES

REVIEW AND ACKNOWLEDGE

CHILDREN'S MEDICAL SERVICES BRANCH

_____ Date: _____
Terry Daffin

_____ Date: _____
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INFORMATION TECHNOLOGY SYSTEMS DIVISION

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_____ Date: _____
Gigi Scott/Nancy Skinner

_____ Date: _____
Bill White

DELTA DENTAL

Date:

Chris Grima

Date:

General

1. All dental services for CCS/GHPP eligible clients require prior authorization from CCS/GHPP.

2. Service authorizations shall be patient, rendering provider, procedure code or group/table specific and, when necessary, tooth or frequency specific.

3. Dental benefits authorized by CCS are limited to children whose CCS eligible condition includes risk factors that compromise their oral health. Not all CCS eligible children receive dental care services as a benefit of the CCS program.

4. All service authorizations shall have a begin and end date. Service authorizations can be authorized for up to a year but it will not extend beyond the client's CCS eligibility period.

5. For children with Medi-Cal benefits only (HAP Aid Code 9N) an authorization does not guarantee payment. The provider is responsible for verifying Medi-Cal eligibility at the time the services are performed.

6. Dental services performed by a dentist or dental anesthesiologist shall be billed to the Dental Fiscal Intermediary following Denti-Cal claim billing guidelines. Dental services performed by a physician or a medical anesthesiologist shall be billed to the Medical Fiscal Intermediary following Medi-Cal claim billing guidelines.

7. Orthodontists and oral surgeons who perform services on CCS eligible clients must be paneled by CCS. CCS paneling requirements conform to the requirements in Title 22, CCR, Section 51223.

8. Dental providers must be enrolled as a CCS/GHPP dental provider and active on the Denti-Cal Provider Master File (PMF) on the date the service is authorized and on the date the service is performed in order to bill for dental services provided to CCS-only and CCS/Medi-Cal clients and to GHPP-only and GHPP/Medi-Cal clients. Providers do not have to be active Denti-Cal providers if they serve only non-Medi-Cal eligible clients.

9. A Special Care Center (SCC) must be enrolled and active on the date the service is authorized. The providers associated with the SCC must be enrolled and active on the Denti-Cal PMF on the date of service.

10. CCS/GHPP claims shall be reimbursed at the billed amount or the current Denti-Cal SMA rates, whichever is lower.

11. All dental service authorization requests for CCS/Medi-Cal beneficiaries that are beyond the scope of the Denti-Cal program shall be submitted to CCS for appropriate review.

12. All dental service authorization requests for GHPP/ Medi-Cal beneficiaries that are beyond the scope of the Denti-Cal program shall be submitted to GHPP for appropriate review.

13. A dental provider must request authorization for conscious sedation or general anesthesia from CCS/GHPP, if required, as part of the dental treatment plan.

14. Requests for treatment, exam, or surgery under general anesthesia, not performed in the office, shall require separate authorizations: one each for the dental provider and the dental anesthesiologist. (Note: Denti-Cal does not reimburse outpatient surgery centers)

15. All requests for EPSDT-Supplemental Services (SS) shall be reviewed by the CMS Branch prior to being routed to PSD-OMDS for review of dental necessity and authorization.

16. Table 19 lists dental procedures that are not within the current Denti-Cal scope of benefits. These services may be authorized as EPSDT -SS for Medi-Cal beneficiaries under the age of 21 years. When these procedures are determined to be medically necessary for a CCS beneficiary or a GHPP beneficiary, they are authorized by CCS/GHPP for both Medi-Cal eligible beneficiaries and beneficiaries who are not eligible for Medi-Cal. When these procedures are authorized for Medi-Cal beneficiaries by CCS/GHPP without prior authorization through the Denti-Cal EPSDT-SS process, claims for reimbursement for such services which are adjudicated pursuant to such a CCS/GHPP authorization are paid from CCS-only or GHPP-only funds as appropriate.

Preventive Dental Services (Table 1)

1. The preventive service authorizations shall cover the procedures listed in Table 1.

Orthodontic Services for Medically Handicapping Malocclusion (Tables 2-5)

1. CCS orthodontic services for medically handicapping malocclusion include 24 treatment visits. CCS shall initially authorize up to 12 treatment visits in the first year.

2. If any authorized orthodontic services are not completed in the year authorized, those services that were not used may be authorized in the following year.

3. Upon receipt and review of a request from an orthodontist for additional treatment visits beyond the initial 24 visits, CCS may authorize 6 or 12 additional visits.

4. Medi-Cal eligible children referred to CCS for orthodontic services and who do not have a CCS eligible craniofacial anomaly**,** cleft lip, and/or palate shall be referred to Denti-Cal for orthodontic evaluation.

5. CCS/Medi-Cal children with handicapping malocclusion that are eligible for orthodontic services by Denti-Cal and who subsequently lose their Medi-Cal eligibility during the course of treatment may have continuing orthodontic services authorized by CCS. The CCS program shall authorize services when the patient is determined to be financially and residentially eligible for the CCS program and the parent/legal guardian signs the application and Program Service Agreement (PSA). An exception to signing of the PSA is made for Healthy Families subscribers, as these children are not required to go through the eligibility screening or signing of the PSA.

6. Any child who becomes Medi-Cal eligible during the course of orthodontic services authorized by CCS shall continue to have orthodontic services authorized by CCS and paid out of CCS funds.

CRANIOFACIAL ANOMALIES, CLEFT PALATE AND/OR CLEFT LIP SERVICES (TABLES 6-12)

1. Following review of orthodontic recommendations from a Craniofacial Center or Cleft Palate Team, CCS shall issue service authorizations according to the guidelines in Tables 6-11 for a CCS client with cleft lip and/or palate, and Table 12 for the CCS client with a craniofacial anomaly.

2. Orthodontic services for a CCS client with cleft palate can span three dentition phases: primary, mixed, and permanent. Services for one phase may start before another has finished.

3. CCS shall authorize orthodontic services for a child with cleft lip using the cleft palate codes in Tables 6-11.

4. If any authorized orthodontic services are not completed in the year authorized, those services that were not used may be authorized in the following year.

OTHER DENTAL SERVICES (TABLES 13-19)

1. CCS shall authorize all necessary restorations on primary teeth (Table 13).

2. **CCS/GHPP shall authorize all necessary restorations on permanent teeth (Table 14).**

3. **CCS/GHPP shall authorize necessary periodontal services (Table 15) regardless of client age and etiology of the periodontal condition.**

4. GHPP shall authorize only Denti-Cal benefits for prosthetics for GHPP clients except in special circumstances when the service is related to their eligible condition.

5. CCS shall not follow Denti-Cal frequency limitations for stayplates. CCS may authorize up to one stayplate each year (Table 16).

6. CCS shall not follow Denti-Cal limitations for certain prosthetics, but will review requests and authorize from the following prosthetic benefits when a stayplate is documented to be inadequate: Partial dentures when not opposed by a full denture (Table 16), fixed permanent bridgework (including at least one pontic) (Table 17), and dental implants (Table 19). Age restrictions may apply for the above benefits.

7. CCS/GHPP shall review and authorize requests for dental implant services (Table 19) on an individual basis.

8. CCS/GHPP shall authorize crowns and posts separately from endodontic procedures.

9. CCS/GHPP shall authorize each endodontic service individually and inform the dental provider that post-treatment films must be submitted with claims for payment. Denti-Cal requires post-treatment

films to be submitted with endodontic claims. If a CCS authorized endodontic claim is submitted without post-treatment films and the client is eligible for Denti-Cal benefits, the claim will be processed according to Denti-Cal rules.

10. Prior authorizations issued for dental services provided under conscious sedation or general anesthesia (Table 18) do not preclude additional services being rendered. If the dental provider discovers the need for additional services during the time that the child is under conscious sedation or general anesthesia, those procedures may be performed without prior authorization. The additional services shall be annotated by the provider on the service authorization form generated by CMS Net which shall be submitted along with narrative documentation of the diagnostic findings made during the treatment session attached to the claim for reimbursement.

11. Requests for dental treatment services not included in the attached tables are authorized after CCS/GHPP receives and reviews a treatment plan from the dentist.

REQUIREMENTS

1. CCS/GHPP shall query the CCS/GHPP Service Authorization File (SAF) by Client Identification Number (CIN) or authorization number.

2. All claims for CCS/GHPP authorized services shall be validated against the SAF to verify recipient, rendering provider, authorization period, and services authorized.

3. The SAF shall always decrement for a specific procedure code when the procedure code is billed. If procedure codes are added to the service authorization form in accordance with Other Dental Services #10, above, these procedures will not be included or decremented on the SAF.

4. Denti-Cal shall develop, if needed, appropriate edits and audits for CCS/GHPP authorized claims. Any changes that affect Denti-Cal scope of benefits shall be addressed through the Dental Operating Instruction Letter (DOIL) or System Development Notice (SDN) process, not as part of E1.

5. CCS/GHPP shall follow Denti-Cal rules for provider adjustments and appeals.

6. The Dental Fiscal Intermediary shall transmit the dental procedure code file to CMSNet. The transmit schedule of the file and/or extract layout shall be finalized at a later point in the design process.

7. The Dental Fiscal Intermediary shall transmit the frequency limitation file to CMSNet. This file will include the dental procedure codes, code descriptions, frequency and age limitations.

8. *Table 1 outlines the preventive dental frequency limitations for CCS/GHPP clients. Services* beyond these limits may be authorized by CCS/GHPP on a case-by-case basis.

9. *For CCS, the county code shall be linked to the claim service line for correct allocation of funds. The County Code will be obtained from the HAP file unless County Code 59 is on the Service Authorization File (SAF).*

ASSUMPTIONS/CONSTRAINTS

1. Patient history will not be accessed during the creation of the CCS/GHPP authorization. CMSNet will not have access to Denti-Cal patient history when creating authorizations.
2. All CCS/GHPP client ID's will be on MEDS.
3. A service authorization shall not override lack of client eligibility on MEDS and/or HAP.
4. CCS/GHPP aid codes shall be on the HAP file.
5. CCS/GHPP claims authorized before implementation of E1 shall be adjudicated through the current claims processing process.
6. All CCS/GHPP dental providers shall be on the Denti-Cal PMF. If dental provider is CCS/GHPP only, they do not have to be enrolled in the Denti-Cal Program but will be on the Denti-Cal PMF.
7. The Special Care Center association indicator shall be on a trailer screen on the PMF for each provider. The SCC number shall define whether the provider is a core team member or a consulting member of a SCC.
8. The CCS/GHPP service authorization number shall be 11 digits.
9. The CCS service authorization number shall have prefix 97.
10. The GHPP service authorization number shall have prefix 99.
11. The reporting category for all service authorizations shall be treatment.
12. The service authorization number shall contain a unique sequencing number.
13. The service authorization shall contain a Julian date.
14. Coordination will be required with all phases of E1 for successful implementation.
15. All DOIL's shall be routed through the CMS Branch to determine if the DOIL's should apply to CCS/GHPP claims.
16. There shall be ongoing review of Denti-Cal edits/audits by CMS to determine if these audits/edits should be or should not be overridden for claims that are authorized by CCS/GHPP.
17. CCS claims are to be paid from the appropriate CCS county allocations. The County Code will be obtained from the HAP file unless County Code 59 is on the SAF.
18. GHPP claims are to be paid from the appropriate GHPP state allocations.

19. CCS/GHPP is responsible for oversight of utilization control and for ensuring the integrity of CCS/GHPP approved providers who are granted authorization for services and the resulting claims. CCS/GHPP shall create and maintain the oversight and management reports necessary for performance of these functions.

20. Authorized services shall be by dental procedure code when the service is not listed in Tables 1-19.

21. The Denti-Cal system has edits in place to modify the claim if the authorization and claim are for different dentition (primary vs. permanent).

22. Dental SCC Consulting Codes will be addressed outside of this document.

23. The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 are not addressed in Dental Enhancement E1.

24. The conduct of CCS Fair Hearings provided for in Division 2, Chapter 13, Article 3 (Section 42705 et seq.) of Title 22 of the California Administrative Code is the responsibility of the Department of Health Services. CCS Fair Hearings are not addressed in Dental Enhancement E1.

DENTAL CODE GROUPS

These dental procedure code groupings are intended to simplify the issuing of dental service authorizations. Exclusion of any dental procedure code within these groupings does not preclude its inclusion within a final treatment plan for a specific CCS/GHPP client, nor do group authorizations require that the services be performed if not necessary.

Note: Numbers in parentheses listed after a procedure code in the following tables indicate the number of times a procedure may be repeated.

TABLE 1, PREVENTIVE DENTAL SERVICES

Code	Description	Issues
010, 015 (4)	Examination	
049, 050 (4)	4 prophylaxis	Denti-Cal covers two per year without additional documentation on a claim basis
or 061, 062 (4)	prophylaxis with fluoride tx.	Change 062 to age 6 and up for CCS.
041, 042, 043, 044, 045, 046	*Sealants*	As many as meets the dental criteria – follow Denti-Cal criteria for appropriate teeth. 041, 042, 043, 044 are new for Denti-Cal and require edits.
116, 117	Bitewing xrays *AND/OR*	Same as Denti-Cal
110, 111	Periapical x-rays *OR*	Same as Denti-Cal
112 or 125 (1)	Intraoral x-rays – complete series ***or*** panographic film	Denti-Cal – 112 once in **3 years -** Denti-Cal covers 125 once in 3 years but more frequently with documentation.
113, 114, 115, 118, 119,120	Intraoral occlusal film; Extraoral, head or lateral jaw; Bitewing, anterior; Photographs	Same as Denti-Cal?
080, 451	Emergency treatment	Same as Denti-Cal?

Table 2, Year One, Orthodontic Services for Medically Handicapping Malocclusion

Code	Description	Issues
552 (1)	Banding and materials	
554 (12)	Treatment visit	
557 (1)	Diagnostic work up and photos	
558 (1)	Study models	
125 (1)	Panographic-film. Single radiograph	
956 (1), 957 (5)	Cephalometric head film	

Table 3, Year Two, Orthodontic Services for Medically Handicapping Malocclusion

Code	Description	Issues
554 (12)	Treatment visit	

Table 4, Year Three, Orthodontic Services for Medically Handicapping Malocclusion

Code	Description	Issues
556 (4)	Quarterly observations	
559 (2)	Retainer, one each, upper and lower	Same as Denti-Cal (1 more of each upper and lower with documentation of necessity)
956 (1), 957 (5)	Cephalometric head film	Beyond Denti-Cal benefits
112 or 125 (1)	Intraoral complete series OR panographic film	Beyond Denti-Cal benefits 112 Same as Denti-Cal
119 (1), 120 (5)	Photograph or slide	Beyond Denti-Cal benefits

Table 5, Year Four, Orthodontic Services for Medically Handicapping Malocclusion

Code	Description	Issues
556 (2)	Quarterly observations	
558 (1)	Study models	

Table 6, Primary Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services

Code	Description	Issues
560 (1)	Diagnostic work up	Payable once per dentist for Denti-Cal (includes study models and photos)
562 (1)	Banding and materials	
564(10) – 10 mos	Treatment visits	
956 (1), 957 (5)	Cephalometric head film	
556 (6) – 18 mos	Quarterly retention observations	
599 (2)	Retainer, one each, upper and lower	
112 or 125 (1)	Intraoral complete series OR panographic film	112 Same as Denti-Cal
119 (1), 120 (5)	Photograph or slide	Beyond Denti-Cal benefits
558 (*no sooner than six months following 560)*	Study models	

Table 7, Mixed Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services

Code	Description	Issues
570 (1)	Banding and materials	Payable once per dentist for Denti-Cal
572 (14) – 14 mos	Treatment visits	
956 (1), 957 (5)	Cephalometric head film	
556 (6) – 18 mos	Quarterly Observations	
558(*no sooner than six months following 570)*	Study models	
599 (2)	Retainer, one each, upper and lower	For each upper and lower
112 or 125 (1)	Intraoral complete series OR panographic film	Beyond Denti-Cal benefits 112 Same as Denti-Cal
119 (1), 120 (5)	Photograph or slide	

Table 8, Permanent Dentition for Cleft Palate and/or Cleft Lip Orthodontic Service for Year 1

Code	Description	Issues
580 (1)	Banding and materials	

582 (12)	Treatment visits	
956 (1), 957 (5)	Cephalometric head film	
112 or 125 (1)	Intraoral complete series OR panographic film	112 Same as Denti-Cal
119 (1), 120 (5)	Photograph or slide	

Table 9, Permanent Dentition for Cleft Palate and/or Cleft Lip Orthodontic Service for Year 2

Code	Description	Issues
582 (12)	Treatment visits	

Table 10, Permanent Dentition for Cleft Palate and/or Cleft Lip Orthodontic Service for Year 3

Code	Description	Issues
582 (6)	Treatment visits	
599 (2)	Retainer, one each, upper and lower	
556 (2)	Quarterly observations	
119 (1), 120 (5)	Photographs or slides	
558 (1)	Study models	
956 (1), 957 (5)	Cephalometric head film	
112 or 125 (1)	Intraoral complete series OR panographic film	112 Same as Denti-Cal

Table 11, Permanent Dentition for Cleft Palate and/or Cleft Lip Orthodontic Service for Year 4

Code	Description	Issues
556 (4)	Quarterly observations	

Table 12, Facial Growth Management Services

Code	Description	Issues
590 (1)	Diagnostic work up	
592 (6)	Quarterly observations (pre-treatment visits)	
598 (24)	Treatment visits	
594 (1)	Progress records prior to treatment	
596 (1)	Banding and materials	
599 (2)	Retainers – removable one each, upper and lower	
556 (6)	Quarterly observations	
119 (1), 120(5)	Photographs or slides	
558 (1)	Study models	
956 (1), 957 (5)	Cephalometric head film	
112 or 125 (1)	Intraoral complete series OR panographic film	112 Same as Denti-Cal

Table 13, Primary Teeth Restorative Dental Services

Code	Description	Issues
600, 601, 602, 603	Amalgam	
645, 646	Composite restorations	
501	Therapeutic pulpotomy	
670, 671	Stainless steel crown	

200, 201, 202, 203, 204, 220, 230, 231, 232	Removal of erupted tooth; Removal of root tip; Removal of unerupted tooth; Postoperative visit, complications	
800, 811, 812	Space maintainers	

Table 14, Permanent Teeth Restorative Dental Services

Code	Description	Issues
611, 612, 613, 614	Amalgam	
645, 646, 648	Composite restorations, pin retention	
502	Therapeutic pulpotomy	
800, 811, 812	Space maintainers	

Table 15, Periodontic Services

Code	Description	Issues
452 (1)	Subgingival curettage and root planing	Current Denti-Cal system allows this limit to be overridden with documentation
472 or 473	Gingivectomy or gingivoplasty per quadrant OR osseous and mucogingival surgery per quadrant	
474	Gingivectomy or gingivoplasy, treatment per tooth (fewer than 6 teeth)	

TABLE 16, REMOVABLE PROSTHETIC SERVICES

Code	Descriptions	Issues
700, 701, 720, 721, 722	Complete denture, denture adjustment, reline	Same as Denti-Cal
702/712 703/704, 705 708/709	*Partial denture, clasps, stress breakers*	*Age restrictions, frequency same as Denti-Cal*
706/716	Stayplate/Clasp	Maximum one per year

TABLE 17, DENTAL SERVICES UNDER CONSCIOUS SEDATION OR GENERAL ANESTHESIA

Code	Descriptions	Issues

Code	Descriptions	Issues
301 or 400	Conscious sedation, General anesthesia	*CCS prior authorization, no other documentation necessary on claim form*
200, 201, 202, 203, 204, 230, 231, 232	Removal of erupted tooth Removal of root tip, Removal of unerupted tooth	
451, 452, 472, 474, 080	Periodontics including emergency treatment, subgingival curettage and root planing, gingivectomy or gingivoplasty	
501, 502, 511, 512, 513, 530, 531, 534	Pulpotomy, root canal therapy, apicoectomy, apexification	
600, 601, 602, 603, 611, 612, 613, 614	Amalgam restorations	
645, 646	Composite or plastic restoration	
670, 671,	Stainless steel crown	
800, 811, 812	Fixed space maintainer	
010, 015 (1)	examination	
049, 050 (1)	prophylaxis OR	Denti-Cal covers two per year without additional documentation
Or 061, 062 (1)	*prophylaxis with fluoride treatment*	Change 062 to age 6 and up for CCS. Still edit that either 049, 050 is given OR 061,062, not both,
041, 042, 043, 044, 045, 046	Sealants	As many as meets the dental criteria – follow Denti-Cal criteria for appropriate teeth. 041, 042, 043, 044 are new for Denti-Cal and require edits
116, 117	Bitewing x-rays ***and/or***	Same as Denti-Cal
110, 111	Periapical x-rays ***or***	Same as Denti-Cal
112 or 125 (1)	Intraoral x-rays – complete series ***or*** panographic film	Denti-Cal – 112 once in **3 years -** Denti-Cal covers 125 once in 3 years but more with documentation
648	**Pin retention**	
706, 716	**Stayplate**	**Maximum one per year**

New Procedure Codes List (Specific to CCS/GHPP)

Code	Description	Issue
041	Sealant-1st deciduous molar	
042	Sealant-2nd deciduous molar	
043	Sealant-1st bicuspids	
044	Sealant-2nd bicuspids	
274	Implants	

APPENDIX C

DENTAL PROCEDURE CODE TABLE

The following data elements will be downloaded to CMS Net from the procedure file:

Data Element / Field Name

- Procedure Number
- Procedure Name
- Status Begin Date
- Status End Date
- Age Min
- Age Max
- Maximum Allowance

APPENDIX D

DENTAL PROCEDURE CODE TRANSLATION TABLE

The following data elements will be downloaded to CMS Net from the Dental Procedure Code Translation table:

Procedure Number	Procedure Number	Procedure Number
3 digit	4 digit	5 digit

SERVICE AUTHORIZATION REQUEST PROCESSING BUSINESS REQUIREMENTS

APPROVALS

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1 INTRODUCTION

All services provided to CCS clients under the CCS program must be authorized in advance by CMS staff. Once the services are approved and a provider has been selected, CMS Net generates an authorization letter that documents the approved services. The letter is sent to the selected providers and the client. The authorization data is stored in CMS Net.

1.1 PURPOSE

This document presents an overview of the high level requirements pertaining to Service Authorization Requests (SAR's). The document presents a brief description of how SAR's will be authorized under E47.

1.2 SCOPE

The scope of the service authorization component of the E47 project is to:

1. Define and standardize the service authorization process so that a single process is used for all CCS counties and regional offices.
2. Issue authorizations on-line that utilize quantifiable, time-limited, and service-specific codes.

1.3 ASSUMPTIONS AND CONTRAINTS

The following assumptions and / or constraints apply to this document:

The implementation must be coordinated with the Fiscal Intermediaries.

Additional specifications and requirements may need to be defined in order to complete the service authorization query process component.

The material contained in this package has been reviewed by users of the CMS Net system. However, a final validation of these requirements must be conducted prior to the commencement of development.

This document does not address user security levels and the functions associated with each security level. Access to specific functions based on an individual's security level must be defined, incorporated in the SAR functional specifications, and implemented as a part of E47.

The SAR screens and its associated processes shall behave similarly when accessed from different screens. Screens will also have a common look, menus, and interface.

This document does not address requirements or changes to CMS Net due to HIPAA. Changes to CMS Net, however, are anticipated as a result of HIPAA requirements. A separate effort will be undertaken to assess and identify HIPAA related changes to

CMS Net. A strategy for implementing HIPAA related changes to CMS Net will be developed upon completion of this assessment. These changes may require modifications to the specifications, functional requirements, or other information contained in this document.

2 GENERAL REQUIREMENTS

2.1 HIGH LEVEL REQUIREMENTS

Users shall access Service Authorizations in CMS Net to create SAR's.

The system shall automatically check a client's eligibility based on the information in the CMS Net client eligibility component after a client is selected to create a SAR.

The system shall not allow user to Authorize or Extend a SAR if client is not eligible for the dates entered on the SAR.

The system shall allow the entry of a SAR that is valid for up to a year.

The system shall prevent the issuance of a SAR that extends beyond the client's CCS eligibility period.

Providers will be chosen from the CMS Net provider master file.

All providers, regardless of provider type, must be enrolled and in active status on the provider master file in order to be added to the SAR and selected to provide services.

The provider's category of service will determine the types of services the provider can be authorized on the SAR.

The provider will determine if the SAR is for medical or dental services.

Only one provider will be allowed for one SAR.

Automated edits shall be applied to SAR's to ensure that program rules governing the processing of SAR's are adhered to.

CMS Net shall automatically generate a printed authorization whenever an authorization is approved, modified, denied, extended or canceled. Multiple copies of the authorization shall be produced and addressed so that they can be sent to the patients and providers on an authorization.

A chronological listing of all authorizations shall be maintained on line in CMS Net. User shall have the ability to view the list of authorizations, select one, and view it on line.

Users shall also be able to print the authorization as necessary.

CMS Net users will require connectivity to the existing full screen case narrative function to add case narratives to a patient's case file.

Ticklers shall be developed to remind users of authorization activities which need to be completed by users. A complete list of the CMS Net ticklers has not yet been identified.

Security levels must be defined, and available system functions shall be associated with these security levels.

Users with a designated security profile shall have the ability to override some of the system edits regarding the entry and authorization of SAR's.

User Help will be required on all of the authorization screens. Help messages and text for the SAR screens will conform to the overall standards set forth E47 enhancements.

Users shall have the ability to generated Reports based on SAR data from the CMS Net database.

2.2 SERVICE AUTHORIZATION REQUEST ENTRY REQUIREMENTS

All SAR's will be specific to a single client.

The client must have a CIN number assigned before a SAR can be generated.

All SAR's will have a unique, 11 digit request number. The specific digits of the request number have not yet been determined, except that the first two digits of all CCS requests will be 97, and the last digit will be zero.

The request number will be generated by CMS Net.

The request number field shall be display only.

The status field shall display the last saved status of the SAR.

The Service Begin Date (the first date that the service can be rendered) is a required and shall default to blank.

The Service Begin Date service can not occur before the Program Begin date (the first date that the client is eligible to receive program services).

The Service Begin Date can not occur after the Program End Date.

The Service End Date (the last date that services covered by the authorization can be rendered) shall default to Blank.

The Service End Date will generally not go beyond client's 21st birthday. Allow for a user with the authority to override this limitation.

The Service End Date will not go beyond the Program End Date (the last date in the clients current eligibility period).

The Service End Date can not occur before the Program End Date.

The Number of Days field shall be automatically calculated when the user enters the Service begin and end dates; alternately, users will be allowed to enter the Service Begin Date and the number of days, and the system will automatically calculate the Service End Date.

The Number of Days field shall not be automatically calculated for Inpatient Hospital provider types. For these provider types, the Number of Days field must be manually input by the user. The number of days cannot exceed the total number of days between the Service Begin Date and Service End Date.

The primary diagnosis will default to the primary diagnosis that is on the face sheet. User can enter another primary diagnosis.

The secondary diagnosis will default to the Secondary diagnosis that is on the face sheet. Users can enter another secondary diagnosis in the Secondary diagnosis. The Secondary diagnosis is optional and may be left blank.

The system shall require “Authorized By” information.

Users shall be able to select a name by scrolling a list of names based on the CMS Net user file.

The system shall require Funding source (diagnosis, treatment, Healthy Families, MTU) information.

The Provider must be selected before services can be entered.

The system shall only allow services to be entered by specific codes.

Service codes shall be selected from a table or file which includes valid codes and prevents the use / selection of invalid or outdated codes.

An authorization may include code specific services or categories of service or both.

All service codes on an authorization must have an associated quantity.

Category of service codes will always have a quantity of “1”

The system shall allow CCS workers, with the security level appropriate, to enter a negotiated price for service codes.

The system shall provide a data element on the authorization that can override the legal county on the HAP file for the recipient. The only allowable entry to this field will be county code 59.

The system shall prevent the entry of services on an authorization, which do not fall within the provider’s scope of services.

The system shall allow code specific authorizations to override any limitations on the category of service.

The system shall not issue authorizations for Drugs with a TAR-2 limitation on the formulary file.

The system shall include a table which lists drugs which require a specific authorization.

Services can be entered by entering a partial service code or description in the Service Code or Description fields.

Users will be allowed to enter a 3, 4, or 5 digit code for a dental service on the SAR. CMS Net shall accept either of these codes for input into the SAR.

A translation table will maintained which cross references the 3, 4, and 5 digit codes.

Services on an authorization for dental services shall be tooth or frequency specific when appropriate.

The system shall include a table which groups dental services into categories of service (similar to medical categories of service). User shall have the ability to authorize dental services by group.

Up to 60 service codes may be entered on one SAR.

The description field will default to the description field that is on the procedure table

User will only be allowed to enter a quantity for procedure codes or NDC codes. It shall default to blank and cannot be updated when a category of service code is selected.

- Authorizations for inpatient hospital provider types shall be for a specific number of inpatient days only.
- The inpatient SAR will not allow for service codes.
- The system shall require “Authorized By” information
- Users shall be able to select a name by scrolling a list of names based on the CMS Net user file.

2.3 DENIAL OF SERVICES REQUIREMENST

A provider must be selected to deny a SAR.

A client must be selected to deny a SAR.

The SAR denial shall have a request number.

The SAR denial shall have a “Date Denied”.

The SAR denial shall have “Denied By” information.

Users shall be able to select a name by scrolling a list of names based on the CMS Net user file.

The SAR denial shall have a Service classification.

The Request must be in “Pending” status to be denied.

Allow “New” or “Pending” SAR’s to be denied with clarifying comments added to the narrative.

The ability to deny requests is subject to a user’s authority and system security level.

The SAR denial shall have a begin date and an end date.

The system must allow for a denial reason.

The SAR denial shall have a Primary Diagnosis.

The SAR denial can have a secondary diagnosis.

The SAR denial shall store the last updated by information.

The SAR denial shall store the date last updated.

2.4 CANCELLATION OF SERVICES

- SAR's that are in "Pending", "Authorized", "Modified", or "Extended" status can be cancelled.
- The ability to cancel SAR's is subject to a user's authority and system security level.
- The Cancelled SAR shall have "Cancelled By" information.
- Users shall be able to select a name by scrolling a list of names based on the CMS Net user file.
- The "Date Cancelled" will cancel the authorization effective the date entered.
- The "Date Cancelled" must occur before the date the Service End Date.

2.5 EXTENSION OF SERVICES

Allow users to "Extend" a SAR that is in Authorized status Authorized, Extended, or Modified status.

Allow the system to "Extend" the SAR by changing the Service End Date or Number of Days.

Allow the user to enter a value in either the Service End Date or Number of Days and the system shall automatically calculate the value.

Allow only the Service End Date, Number of Days, Extended By and Date Extended values to be changed.

Extended authorizations will be assigned a new authorization number and all of the data elements listed in the Authorize transaction for the newly extended authorization will be sent to the SAF.

The Service Begin Date for the extended authorization will be the day after the service end date of the original authorization. This date will be automatically calculated by CMS Net. The original authorization (which was extended) will subsequently remain in effect until its service end date occurs.

Allow Authorized SAR's to be extended any number of times (e.g., an authorization in Extended status can be extended again).

The "Date Extended" will default to blank and must be inputed by the user.

The system shall require "Extended By" information.

Users will be able select a value for this field by scrolling a list of names based on the CMS Net user file.

The Service End Date will generally not go beyond client's 21st birthday.

Allow for a user with the authority to override the 21st birthday limitation.

2.6 MODIFICATION OF SERVICES

- The user shall have the ability to correct errors or omissions in a SAR.

At least one user changeable field must be modified on this screen to change the status to Modified.

The provider can not be modified using this screen.

Only the Service Code, Quantity or Units can be modified.

Authorizations which are in “Extended” status cannot be modified.

The ability to modify authorizations is subject to a user’s authority and system security level.

SERVICE AUTHORIZATION QUERY PROCESSING BUSINESS REQUIREMENTS

APPROVALS

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SERVICE AUTHORIZATION QUERY PROCESSING BUSINESS REQUIREMENTS VII

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2 GENERAL REQUIREMENTS I

2.1 high level requirements i

1 INTRODUCTION

All services provided to CCS clients under the CCS program must be authorized in advance by CMS staff. A very important part of issuing Service Authorizations is the ability for CMS staff to query existing Service Authorizations and related files and tables. This allows the CMS staff to better case manage the CCS clients.

1.1 PURPOSE

This document presents an overview of the high level requirements pertaining to the Service Authorization query processes.

1.2 SCOPE

The table below identifies the queries which have been identified and which require development.

Table 1-1, Service Authorization Queries

Item	Purpose
Service Authorization Query	Used to query for authorizations on CMS Net. It will not initiate a query of the SAF file
Procedure Code Inquiry	An inquiry to the Procedure Code Table.
Provider File Inquiry	An inquiry to the CMS Net Provider File.
Formulary File Inquiry	An inquiry to the Formulary File Table.
Dental Procedure Code Inquiry	An inquiry to the Dental Code Table

1.3 ASSUMPTIONS AND CONTRAINTS

The following assumptions and / or constraints apply to this document:

- Additional specifications and requirements may need to be defined in order to complete the service authorization query process component.
- The material contained in this package has been reviewed by users of the CMS Net system. However, a final validation of these specifications must be conducted prior to the commencement of development.
- This document does not address user security levels and the functions associated with each security level. Access to specific functions based on an individual's security level must be defined, incorporated in the SAR functional specifications, and implemented as a part of E47.
- The SAR query screens and its associated processes shall behave similarly when accessed from different screens. Screens will also have a common look, menus, and interface.
- This document does not address requirements or changes to CMS Net due to HIPAA. Changes to CMS Net, however, are anticipated as a result of HIPAA requirements. A separate effort will be undertaken to assess and identify HIPAA related changes to CMS Net. A strategy for implementing HIPAA related changes to CMS Net will be developed upon completion of this assessment. These changes may require modifications to the specifications, functional requirements, or other information contained in this document.

2 GENERAL REQUIREMENTS

2.1 HIGH LEVEL REQUIREMENTS

- Allow the users to query All Service Authorizations in CMS Net.
- Allow users to inquiry tables related to SAR processing.
- Allow the user to initiate a query of the Procedure Code, Provider File Code, Formulary File, or Dental Procedure tables in CMS Net.
- Allow different values to be used as query search criteria.
- Allow full or partial value to be entered to invoke a query.
- The results of queries will be “Display Only”.

SERVICE AUTHORIZATION TRANSACTION PROCESSING BUSINESS REQUIREMENTS

APPROVALS

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SERVICE AUTHORIZATION TRANSACTION PROCESSING BUSINESS REQUIREMENTS II

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TABLE OF CONTENTS II

1 INTRODUCTION 1

1.1 Purpose 1
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2 GENERAL REQUIREMENTS I

2.1 high level requirements i

1 INTRODUCTION

All services provided to CCS clients under the CCS program must be authorized in advance by CMS staff. When a Service Authorization Request (SAR) is initially approved by a CCS caseworker, CMS Net will send an electronic transaction to either the medical (EDS) or dental (Delta Dental) fiscal intermediary. The transaction will include information on the approved authorization, such as the authorization number, patient name, provider name, and the number and type of authorized services. CMS Net will utilize standard codes for authorizations and procedures, and all authorizations will have a unique authorization number. This information will be stored in CMS Net and one of two Service Authorization Files (SAF) that will exist at the medical (EDS) and dental (Delta Dental) fiscal intermediaries.

1.1 PURPOSE

This document presents an overview of the high level requirements pertaining to the SAR transactions. The document presents a brief description of the transactions that will be developed under E-47. Under E-47, the fiscal intermediaries will use authorization data to validate and adjudicate claims. In order to support the fiscal intermediary's claims processing functions, CMS Net must send data to the SAF at the medical and dental fiscal intermediaries for authorized, modified, canceled, and extended SAR transactions. These four transactions will provide the data elements necessary to populate the SAF.

1.2 SCOPE

Transactions between CMS Net and the SAF will be "one way", e.g. CMS Net will send transactions to each SAF but will not receive any data from the fiscal intermediaries in return. The fiscal intermediaries will be responsible for developing and maintaining the SAF. The data will be sent to the SAF on a batch basis.

1.3 ASSUMPTIONS AND CONTRAINTS

The following assumptions and / or constraints apply to this document:

- CCS/GHPP claims authorized before implementation will adjudicate through the current claims processing process. The SAF will not be populated by authorizations generated prior to the implementation of E47.
- Additional specifications and requirements may need to be defined in order to complete the service authorization query process component.
- The material contained in this package has been reviewed by users of the CMS Net system. However, a final validation of these specifications must be conducted prior to the commencement of development.

- This document does not address user security levels and the functions associated with each security level. Access to specific functions based on an individual's security level must be defined, incorporated in the SAR functional specifications, and implemented as a part of E47.
- This document does not address requirements or changes to CMS Net due to HIPAA. Changes to CMS Net, however, are anticipated as a result of HIPAA requirements. A separate effort will be undertaken to assess and identify HIPAA related changes to CMS Net. A strategy for implementing HIPAA related changes to CMS Net will be developed upon completion of this assessment. These changes may require modifications to the specifications, functional requirements, or other information contained in this document.

2 GENERAL REQUIREMENTS

2.1 HIGH LEVEL REQUIREMENTS

The following high level requirements apply to the Service Authorize transaction processing:

- CMS Net will send by batch transactions to the fiscal intermediaries the data elements for each authorized SAR. These data elements will establish the initial record of the authorization in the SAF. These data elements may be modified with a modification, extension, or cancellation transaction.
- The Authorize transaction will establish the initial record in the SAF, and will include all of the data initial elements required to establish a SAF record for the SAR. Modify, cancel, and extend transactions will change a previously established record (by the Authorize transaction) in the SAF.
- The same data elements will be sent to both the dental and medical fiscal intermediaries.
- The SAF will be updated on a batch basis. Transactions which are generated by CMS Net outside of the set batch cycle will held until the next batch transaction can be transmitted to the SAF.
- The fiscal intermediaries will be responsible for the maintaining the SAF (the file itself). CMS staff, using CMS Net, will be responsible for the data transmitted to the SAF.
- Only authorized SAR's will be sent to the SAF. Cancellation, modification, and extension transactions will be sent to the SAF to update the data elements of previously authorized requests.
- CCS/GHPP staff will be allowed to query the SAF by client ID (CIN) or authorization number. This ability will be provided through EDS Net / CAMMIS rather than CMS Net.
- All SAR's, except SAR's for Inpatient Hospital, will have at least one service code. A SAR may have up to 60 service codes on a single authorization. SAR's for Inpatient Hospital will only have Begin and End Dates and a Number of Days on the SAF transaction.
- The SAF transaction will contain service authorizations for both CCS and GHPP. These specifications, however, only pertain to CCS service authorizations.

SERVCIE AUTHORIZATION SYSTEM ADMINISTRATION TABLE MAINTENANCE REQUIREMENTS

APPROVALS

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Krista Novotny, EDS. Date

Reviewed by:

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Terry Daffin, VIP, Inc. Date

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Date

Approved by:

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Betsey Lyman, Assistant Chief Date

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Irvin White, Chief, Program Support Section Date

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1 INTRODUCTION

All services provided to CCS clients under the CCS program must be authorized in advance by CMS staff. Once the services are approved and a provider has been selected, CMS Net generates an authorization letter that documents the approved services. The letter is sent to the selected providers and the client. The authorization data is stored in CMS Net.

1.1 PURPOSE

The selection of providers and services will be supported by several tables and files which will be downloaded to CMS Net from the Fiscal Intermediaries. These tables and files will support lists that users will scroll to select providers and services. The tables and files will also have data elements which CMS Net will use to apply edits to the selection of providers and services to ensure that these selections are consistent with CCS program and policy rules.

1.2 SCOPE

CMS Net will need to maintain the new tables that will support Service Authorizations. These new tables and files will need to be maintained in CMS Net.

1.3 ASSUMPTIONS AND CONTRAINTS

The following assumptions and / or constraints apply to this document:

- Most of the tables and files for Service Authorization are based on Medi-Cal and Denti-Cal tables and files. Therefore, the source tables will reside at the fiscal intermediaries and will be downloaded to CMS Net.
- Additional tables may be identified and added to CMS Net during the detailed design phase.
- The material contained in this package was in development stages at the time the RFP is released. Some additional specifications and requirements may need to be defined in order to complete the service authorization query process component.
- The material contained in this package has been reviewed by users of the CMS Net system. However, a final validation of these specifications must be conducted prior to the commencement of development.
- This document does not address user security levels and the functions associated with each security level. Access to specific functions based on an individual's security level must be defined, incorporated in the SAR functional specifications, and implemented as a part of E47.

- The standard process for updating Tables will be used to change table values. All Medi-Cal Operating Instruction Letters (OILS) and Dental Operating Instruction Letters (DOILS) impacting the tables downloaded to CMS Net will be routed to CMS so that the impact of the changes on CCS can be assessed
- This document does not address requirements or changes to CMS Net due to HIPAA. Changes to CMS Net, however, are anticipated as a result of HIPAA requirements. A separate effort will be undertaken to assess and identify HIPAA related changes to CMS Net. A strategy for implementing HIPAA related changes to CMS Net will be developed upon completion of this assessment. These changes may require modifications to the specifications, functional requirements, or other information contained in this document

2 GENERAL REQUIREMENTS

2.1 HIGH LEVEL REQUIREMENTS

- Develop and maintain new tables for Service Authorizations.
- Allow system to accept tables downloaded from the Fiscal Intermediaries (FI's).
- CMS Net shall update the tables whenever applicable changes are made to the source table at the FI's.
- Do not allow the system to update table or files that are downloaded from the FI's.
- Allow users to update Service Authorization tables created in CMS Net.

SERVICE AUTHORIZATION INTEGRATION BUSINESS REQUIREMENTS

APPROVALS

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1 INTRODUCTION

All services provided to CCS clients under the CCS program must be authorized in advance by CMS staff. Once the services are approved and a provider has been selected, CMS Net generates an authorization letter that documents the approved services. The letter is sent to the selected providers and the client. The authorization data is stored in CMS Net.

1.1 PURPOSE

This document presents an overview of the high level business requirements pertaining to the Service Authorization integration process. It will give a brief description on how the new Service Authorization file in CMS Net will be integrated with the CMS Net Eligibility process and the Provider File CMS Net.

1.2 SCOPE

The conversion of the CMS NET screens from "roll and scroll" to full screen implementations will include changes and enhancements to existing functionality. This document focuses on the Service Authorization integration with the CMS Net Provider file and Eligibility.

1.3 ASSUMPTIONS AND CONTRAINTS

The following assumptions and / or constraints apply to this document:

- The CMS Net Provider File and the Eligibility processes must be completed prior to Service Authorization implementation.
- The material contained in this package has been reviewed by users of the CMS Net system. However, a final validation of these specifications must be conducted prior to the commencement of development.
- This document does not address requirements or changes to CMS Net due to HIPAA. Changes to CMS Net, however, are anticipated as a result of HIPAA requirements. A separate effort will be undertaken to assess and identify HIPAA related changes to CMS Net. A strategy for implementing HIPAA related changes to CMS Net will be developed upon completion of this assessment. These changes may require modifications to the specifications, functional requirements, or other information contained in this document.

2 GENERAL REQUIREMENTS

2.1 HIGH LEVEL REQUIREMENTS

- Service Authorizations shall use the CMS Net Provider file to select, query, and verify provider information.
- Service Authorizations shall use the CMS Net Eligibility information.

SERVICE AUTHORIZATIONS CONVERSION BUSINESS REQUIREMENTS DOCUMENT

APPROVALS

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1 INTRODUCTION

All services provided to CCS clients under the CCS program must be authorized in advance by CMS staff. Once the services are approved and a provider has been selected, CMS Net generates an authorization letter that documents the approved services. The letter is sent to the selected providers and the client. The authorization data is stored in CMS Net.

1.1 PURPOSE

This document presents an overview of the high level business requirements pertaining to the Service Authorization conversion process. The document presents a brief description of how the current Service Authorization file in CMS Net will be convert to the New Service Authorization Request (SAR) file under E47.

1.2 SCOPE

The conversion of the CMS NET screens from "roll and scroll" to full screen implementations will include changes to existing functionality. This document focuses on the Service Authorization conversion.

The data that is currently stored in CMS Net for service authorizations does not meet all of the data requirements for the new Service Authorization Request (SAR)file that will be created.

1.3 ASSUMPTIONS AND CONTRAINTS

The following assumptions and / or constraints apply to this document:

- Requests Entered, Authorized, Denied, Cancelled, or Modified prior to implementation of E47 will not be converted but will be accessed through the Display Events function of the CMS Net legacy system. The authorizations in the legacy system will be display only. If modifications to an authorization in the legacy system are required, a new SAR must be created through the enhanced CMS Net system.
- Additional specifications and requirements may need to be defined in order to complete the service authorization conversion component.
- The material contained in this package has been reviewed by users of the CMS Net system. However, a final validation of these specifications must be conducted prior to the commencement of development.
- This document does not address requirements or changes to CMS Net due to HIPAA. Changes to CMS Net, however, are anticipated as a result of HIPAA requirements. A separate effort will be undertaken to assess and identify HIPAA related changes to CMS Net. A strategy for implementing HIPAA related changes to CMS Net will be developed upon completion of this assessment. These changes

may require modifications to the specifications, functional requirements, or other information contained in this document.

2 GENERAL REQUIREMENTS

2.1 HIGH LEVEL REQUIREMENTS

- Do not convert legacy CMS Net Service Authorizations to the Service Authorization Request file in CMS Net.
- Legacy CMS Net Authorizations shall be Read Only after implementation.
- User shall have the ability to view legacy CMS Net Authorizations through Display Events.